

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8001895				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR PM	
Robert T. Ailes						1 15 80		11:45 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		May 4 1905		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Kentucky		U.S.A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR POSTMORTEM WORKING HRS)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring, Md.		Bel-Pre Health Care Center				C. & P. Telephone		Supervisor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11215 Oakleaf Drive	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Ailes		Susan Pheneger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No		577-01-1194		Maude Ailes (Wife) Same as Above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Respiratory Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <i>Cancer of the Lung - oat cell</i>									
(c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<i>none</i>		<i>none</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>1-4-80</i> to <i>1-13-80</i> , that (we) last saw the deceased alive on <i>1-4-80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles Franklin</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-17-80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. Charles Franklin		11200 New Hampshire Ave., Silver Spring, Md/							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/18/80		Ft. Lincoln Cemetery		Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi Funeral Home		1800 New Hampshire Ave. Silver Spring, Md		JAN 2 1980		<i>Jeffrey McCreedy</i>			





#1, Film G540 2/27/80 kam

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 8 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Hilda</b>		FIRST <b>P</b>		MIDDLE <b>Allnut</b>		LAST <b>Allnut</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 23 80</b>		2b. HOUR <b>10:33am</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 26 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK A. ALLNUTT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA R. PERRY</b>				13e. STREET ADDRESS <b>9701 FIELDS RD.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-0345</b>		17. INFORMANT ADDRESS <b>GUY F. ALLNUTT (SAME AS 13e)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> 4151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> , 19 <b>83</b> , to <b>1-23</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1-21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>D. C. Bucy</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-23-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. C. Bucy</b>				22e. ADDRESS <b>809 Veris Mill Rd Rockville</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MONOCACY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEALLSVILLE MONTG MARYLAND</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>				25a. DATE REC'D BY REGISTRAR <b>2/1/80</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

Released by Dr. John Ball, Deputy Medical Examiner

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO JESUS IN THE TOP SECRET DOCUMENTS EXHIBIT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 01897			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				2b. HOUR							
William Lee Allwine												DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR				2:04 PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR							
Male		White		3/ 17/ 23		56 YRS.		MONTHS DAYS		HOURS MIN.		Jan 3, 1980				2:04 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, D. C.						United States						Montgomery				MD.							
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring						Holy Cross Hospital of Silver Sp						OFFICER				DEPT OF DEFENSE							
13a. STATE						13b. CITY OR TOWN						13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS									
Maryland						Montgomery						YES <input type="checkbox"/> NO <input type="checkbox"/>		1111 University Blvd W, #617									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST						FIRST MIDDLE LAST																	
JACOB MARTIN ALLWINE						MARY AIKEN																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS											
YES						WW II						578-26-2764						wife, Marjorie 1111 University Blvd W,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4291 (b) <u>Chronic Myocardial Dis.</u> (c) <u>4 yrs.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
<u>None</u>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
						P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION											
												STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED											
<u>John S. Rogers</u>						M.D. <u>Doc</u>						Jan 31 1980											
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																	
JOHN S. ROGERS						1919 SEMINARY ROAD, SILVER SPRING, MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY											
BURIAL						1/7/80						FORT LINCOLN											
23d. LOCATION						23e. COUNTY						23f. STATE											
BRENTWOOD						PRI						GEO MD.											
24. FUNERAL DIRECTOR NAME						24b. ADDRESS						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
FRANCIS J. COLLINS						500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						JAN 9 1980				<u>Barry McCurdy</u>							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 8 9 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>AUGUST HERBERT</b> <i>Herbert August Almgren</i>		LAST <b>ALMGREN</b> <i>August Almgren</i>		2a DATE OF DEATH MONTH DAY YEAR <b>1 - 15 - 80</b>		2b HOUR <b>6:51 AM</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 3 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOK BINDER JUDG</b>		12b KIND OF BUSINESS OR INDUSTRY <b>AND DETWIELER</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>MARYLAND PRI GEO MT. RAINIER</b>		13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS <b>2901 ARUNDEL ROAD</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST ALMGREN</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLEN ANDERSON</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>578-05-7743</b>		17 INFORMANT <b>SON</b>		ADDRESS <b>3906 WAKEFIELD LANE BOWIE, MARYLAND</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition &amp; Cardiovascular Complications</i> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Melanotic Carcinoma of Uterus</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a DATE OF OPERATION <b>12/30/79</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rt. Hip Fracture</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>11/1/80</b> 19 <b>79</b> to <b>1/15</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/1/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Douglas K. Potts, MD</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>1/15/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Douglas K. Potts, MD</b>		22e ADDRESS <b>831 UNIVERSITY BLVD. E. SILVER SPRING</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>1/17/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>	
24 FUNERAL DIRECTOR'S NAME <b>FRANCIS J. COLLINS</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a DATE REC'D. BY REGISTRAR <b>JAN 16 1980</b>		25b REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>	

MEDICAL CERTIFICATION

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



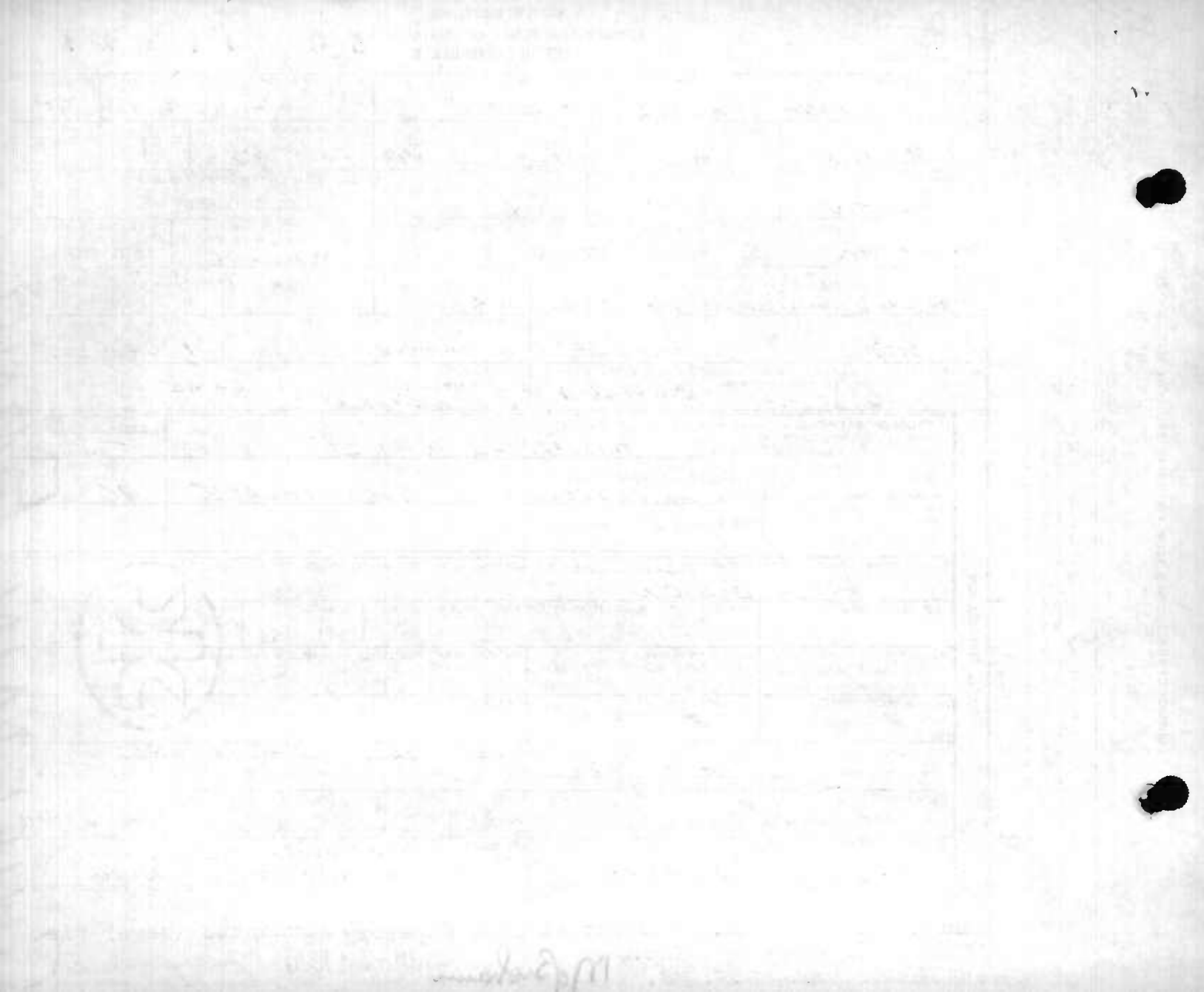
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8001899									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ANNA LOUISE ANDERSON								JANUARY 16 1980		9P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		DEC 24 1893		86 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WISCONSIN		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		711 Boston Avenue,				HOUSEWIFE		own home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		MONTGOMERY		TAKOMA PARK				711 BOSTON AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
OTTO LINDNER						MINNIE DICKENET					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		---		392-03-0646		DAUGHTER		SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT										MINUTES	
410- DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) ARTERIOSCLEROTIC HEART DISEASE										10 YEARS	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
HYPERTENSION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1965 to JAN 16 1980, that (I) (we) lost the deceased on JAN 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Kreichmar				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JAN 16 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ROBERT L. KREICHMAR				7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Jan 21-80		Forest Home Cemetery		Marinette (same)		Wise.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.											
25a. DATE REC'D. BY REGISTRAR JAN 24 1980											
25b. REGISTRAR'S SIGNATURE [Signature]											





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PMI 3". RETAIN PAGE 5 FOR YOUR OFFICE. IF THE DECEASED WAS A RESIDENT OF BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>JESSE SAMUEL AYTON</b>						2a. DATE KNOWN OF DEATH MATED <b>Jan 30, 1980</b>					
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov. 7 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>Jan 30, 1980</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Geriatric Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Lytonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6020 Lytonsville Rd.</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>William</b> LAST <b>Ayton</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Zadie</b> MIDDLE <b>Ellen</b> LAST <b>Ayton</b>				17. INFORMANT ADDRESS <b>Ethelene E. Ayton Same as #13</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578-44-2011</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dia</b> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dr. John Rogers</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>Dr. John Rogers</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. John Rogers</b>				ADDRESS <b>Silver Spring, Md.</b>				DATE SIGNED <b>Jan 30, 1980</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb. 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>		23d. LOCATION CITY OR TOWN <b>Laytonsville</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



61811 MO - 20 8801 - 10111111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 6001901							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine Elizabeth Bagley						2a. DATE OF DEATH MONTH DAY YEAR January 23, 1980		2b. HOUR 7:08P <sup>M</sup>	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1916		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 63		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medicine	
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN McLean		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1316 Oberon Way	
14 FATHER'S NAME FIRST MIDDLE LAST Patrick - McCabe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Lafferty							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b. SOCIAL SECURITY NO. 047-28-7676		17 INFORMANT ADDRESS Mr. Christopher Bagley, son of McLean, Va 22102					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIVER FAILURE 193- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) ANAPLASTIC CARCINOMA OF THYROID DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from June 13, 1979, to January 23, 1980, that (1) (we) last saw the deceased alive on January 23, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) we did not view the body after death.									
22b. SIGNATURE MARC E. LIPPMAN		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC E. LIPPMAN		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland-Prince Geo. Co.-Md.			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home-Silver Spring, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 30 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready			

MEDICAL CERTIFICATION

0155

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8001902

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie Lillian Balderson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 1, 1980</b>			2b. HOUR <b>4:16 pm</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 20, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOOD SERVICES DIRECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOVT.</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3612 EDELMAR TERRACE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>RYLAND SANFORD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA SCRINGER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-28-5140</b>		17. INFORMANT <b>SON</b>		ADDRESS <b>10029 TENBROOK DR. SILVER SPRING, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Signs</u> (c) <u>Colon adenocarcinoma metastasized to liver</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>										
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:15 P.M. 1/1 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>80</u> , to <u>1/1</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ASCHENBOLD, MD</b>				22e. ADDRESS <b>MGH</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/4/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DELPHI PRI GEO MD.</b>				
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1980</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 0 0 1 9 0 3				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR		
Nellie M. Balenger					1/21/80			8:45 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		Caucasian		Feb. 3, 1897		82 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington DC		U.S.A.				Montgomery MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Hospital				Homemaker		Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
Maryland Montgomery Glen Echo					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6105 Bryn Mawr Avenue			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
William Hamilton Kline					Mary Alberta Palmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					220-44-7332		Betty J. Briggs same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								1WK		
4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE								10YRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CIRCULATORY ACCIDENT										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
				HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET				
22a. I certify that (I) (the hospital) attended the deceased from 9/16, 1969, to 1-21, 1980, that (I) (we) last saw the deceased alive on 1-19-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
Stephen W. D. Jr., M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1-21-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
STEPHEN W. DEJTER, M.D.				6719 W 230N LANE, BETHESDA, MD 20834						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			1/24/80		Fort Lincoln		Bladensburg, Maryland			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND						JAN 28 1980		Barney McCready		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8001904			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) <del>Lester</del> <i>Lester G. Barnes</i>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
3. SEX <i>male</i>				4. RACE <i>white</i>			
5. DATE OF BIRTH MONTH DAY YEAR <i>3 22 1900</i>				6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Pre Health Care Center</i>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machinist</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Navy Yard</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Mont.</i> 13c. CITY OR TOWN <i>Olney</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>3314 Emory Church Road</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel W. Barnes</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hattie H. Day</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>219-42-4760-A</i>			
17. INFORMANT ADDRESS <i>Lucille J. Barnes "same as # 13"</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1629</i> DUE TO, OR AS A COMPLICATION OF (b) <i>ACUTERIA + NANITION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>PERITONITIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>PERITONITIS Lung</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 YEAR</i> <i>3 YRS.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>PLEURAL EFFUSION - ASCD.</i>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> <i>1969</i> to <i>1/17</i> <i>80</i> , the date of death.				21h. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> <i>1969</i> to <i>1/17</i> <i>80</i> , the date of death.			
21i. SIGNATURE <i>Donald R. Lewis</i>				21j. DATE SIGNED <i>1/17/80</i>			
21k. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. R. LEWIS MD</i>				21l. ADDRESS <i>OLNEY, MARYLAND 20832</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jan. 21, 1980</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>			
24. FUNERAL DIRECTOR <i>Francis H. Barber Laytonsville, Md. 20760</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1980</i> 25b. REGISTRAR'S SIGNATURE <i>Lester G. Barnes</i>			



CHIEF OF POLICE

FOR CATION



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0001905

1. DECEASED NAME (TYPE OR PRINT) James C. Barron			2a. DATE OF DEATH MONTH DAY YEAR Jan. 3, 1980			2b. HOUR 7:30 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treas.		12b. KIND OF BUSINESS OR INDUSTRY VEMCO	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5912 Johnson Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST James (NMI) Barron					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Mac Donald				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 067-09-5503		17. INFORMANT Marian F. Barron			ADDRESS Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>RHEUMATIC HEART DISEASE</u> (c) <u>55 YRS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 23, 1965</u> to <u>Jan 3, 1980</u> , that (I) (we) last saw the deceased alive on <u>Jan 2, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leo I. Donovan</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan. 3, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo I. Donovan					22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Union Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Weatherly, Pa.		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.					25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315



OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315

20315-20315-20315



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8001906

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>FANNYE L. BECKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 3, 1980</b>			2b. HOUR <b>7:25 AM</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>FEB. 15, 1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery CO. MD.</b>				
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPG.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS <b>APT. 1219 1121 UNIV. BLVD. WEST #20902</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES LEVENWALL</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PESHA LEVENSON</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>NO</b>			17 INFORMANT <b>MR. HEBERT BECKER</b>			18. ADDRESS <b>1121 UNIVERSITY BLVD. APT. 1219 SILVER SPRING, MD 20902</b>				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>5990</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>MULTIPLE PATHOGENS</b> (c) <b>URINARY INFECTION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SEVERE ORGANIC BRAIN SYNDROME</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/11/73</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6121 MONTROSE RD. ROCKVILLE BALTIMORE MARYLAND</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11/73</b> to <b>1/3/80</b> , that (I) (we) last saw the deceased alive on <b>1/3/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)										
22b. SIGNATURE <b>D.D. PATEL</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/3/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.D. PATEL</b>			22e. ADDRESS <b>6121 MONTROSE RD. ROCKVILLE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JAN. 6, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Forney/Kelley</b>		

MEDICAL CERTIFICATION



JAN 8 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR		01907									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JOSEPH BENVENUTO				20. DATE KNOWN OF DEATH				21. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. DATE PRONOUNCED DEAD		11. HOUR	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION		13. KIND OF BUSINESS OR INDUSTRY		14. DATE		15. HOUR	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. DATE		20. HOUR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. (b)		22. DUE TO, OR AS A CONSEQUENCE OF		23. (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21. YES		22. NO	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		22. DATE		23. HOUR		24. MIN	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22. CITY OR TOWN		23. COUNTY		24. STATE	
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:	
Natural causes		Accident		Suicide		Homicide		Undetermined manner		TITLE (SPECIFY)	
ACTUAL SIGNATURE		M.D.		MEDICAL EXAMINER		DATE SIGNED		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
EXAMINER'S NAME		ADDRESS		27. BURIAL, CREMATION, REMOVAL		28. DATE		29. NAME OF CEMETERY OR CREMATORY		30. LOCATION	
27. BURIAL, CREMATION, REMOVAL		28. DATE		29. NAME OF CEMETERY OR CREMATORY		30. LOCATION		31. CITY OR TOWN		32. COUNTY	
31. CITY OR TOWN		32. COUNTY		33. STATE		34. DATE		35. HOUR		36. MIN	
37. FUNERAL DIRECTOR		ADDRESS		38. DATE REC'D. BY REGISTRAR		39. REGISTRAR'S SIGNATURE		40. DATE		41. HOUR	
42. FUNERAL DIRECTOR		ADDRESS		43. DATE REC'D. BY REGISTRAR		44. REGISTRAR'S SIGNATURE		45. DATE		46. HOUR	



W. L. WILSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8001908			
1. DECEASED NAME (TYPE OR PRINT) RUTH M. BLOCK				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1980				2b. HOUR 5:20 PM			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 20, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Ind. Assn.			
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4400 East-West Highway, #432			
14 FATHER'S NAME FIRST MIDDLE LAST Matthew Martin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Eldridge							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 406-22-0157		17 INFORMANT ADDRESS Seymour Block, Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 1629 CANCER OF LUNG, METASTATIC DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/15, 1980, to 1/19, 1980, that (I) (we) lost saw the deceased alive on 1/18, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ralph M. Coan				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH M. COAN MD				22e. ADDRESS 4400 EAST WEST HWY BETHESDA, MD. 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1-20-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland						25. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE JAN 24 1980					

• C • M • Y • K

NOTES

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 01909

1. DECEASED NAME (TYPE OR PRINT)		FIRST Lulu		MIDDLE M		LAST Blue		2a. DATE KNOWN OF DEATH ESTIMATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		7b. HOUR 5:50 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Mar. 6, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1.21.1980		2d. HOUR 5:58 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE DC				13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1853 S Street, NW					
14. FATHER'S NAME FIRST MIDDLE LAST Randolph Blue				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Washington									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-50-7581		17. INFORMANT ADDRESS Elizabeth B. Jones 1327 Kenyon ST.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyper-Tensive Cardiovascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John S. Ball</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED <u>Jan, 21, 1980</u>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/25/1980		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland			
24. FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc.						ADDRESS 1432 You St., NW		25a. DATE REC'D. BY REGISTRAR JAN 28 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JACOB		BONDAROFF		1-8-80		8:08 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		MAY 15, 1905		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
RUSSIA		U.S.A.				MONTGOMERY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		SALESMAN		USED FURNITURE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		PRINCE GEORGES		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2208 CHARLESTON PLACE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NATHAN		BONDAROFF		ETHEL		SPECTOR		8714 SUNDAL DRIVE, SYLVIA B. BLUMENTHAL, SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)		18a. IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF		18c. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
185- METASTATIC CARCINOMA OF THE PROSTATE								1 YR	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
DIABETES MELLITUS PARKINSON'S DISEASE						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		HOUR A.M. MONTH DAY YEAR				21f. LOCATION		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED	
show the deceased alive on		JAMES H. BROWN		DR. JAMES BROWN, M.D.		6525 BELCREST ROAD, SUITE 460, HYATTSVILLE,		1/8/80	
above, (I) (we) (did) (did not) view the body after death.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
BURIAL		1/9/1980		MOUNT LEBANON CEMETERY		ADELPHI PRINCE GEORGES MD.		JAN 11 1980	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. CITY OR TOWN		24d. STATE	
DANIEL M. STEIN HEBREW MEMORIAL FUNERAL HOME				232 CARROLL STREET, N. W., WASHINGTON, D. C.					

A.2.0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 01911

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		DATE ESTIMATED		MONTH DAY YEAR	
BETTY IRENE BOONE		1-1-80		12	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
FEMALE	WHITE	12 15 58	21	MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
Rockville		SHADY GROVE ADVENTIST HOSPITAL		Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville		SHADY GROVE ADVENTIST HOSPITAL		Typist	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD.		MONT.		BOYDS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Herbert		Lula		No	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Lula Boone		PART 1 DEATH WAS CAUSED BY:			
		IMMEDIATE CAUSE (a) Crushed Skull			
		DUE TO, OR AS A CONSEQUENCE OF			
		(b) Trauma Auto Accident			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		1:00 PM 1-1-80		Car ran into fence at intersection of Hwy 101 and Hwy 102	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		Street		Clappert Rd. Boyds Montgomery Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John G. Ball		Deputy		Jan 1, 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		Md.	
John G. Ball, Deputy		7936 Old Georgetown Rd., Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 4, '80		Resthaven Memorial Cem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gartner-Sandison F. M. Gaithersburg, Md. 20760		JAN 1980		Frederick Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 0 1 9 1 2 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Willard A Botzum JR.			2a. DATE OF DEATH MONTH DAY YEAR 1-25-80		2b. HOUR 11 P. M.
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 5 13 18		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY John Hopkins
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Sil. Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Willard A. Botzum, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 11		17 INFORMANT ADDRESS Marie C. Botzum-wife-(same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LYMPHOMA 2028 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA, LEUKEMIA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from 19 78, to 1/25 19 80, that (I) (we) lost saw the deceased alive on 1/25 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE Daniel Rosenberg		DEGREE MD		22c DATE SIGNED 1/25/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM		22e ADDRESS 10900 CONNECTICUT AVE. KENSINGTON, MD 20795			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE -28-80	23c NAME OF CEMETERY OR CREMATORY Metropolitan		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.	
24 FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a DATE REC'D. BY REGISTRAR JAN 31 1980		25b REGISTRAR'S SIGNATURE Lisby McCreedy	
26 ADDRESS 8434 Ga. Ave., S.S. Md. MaBroham					







DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 01913	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Blanche Melvina Bozarth</b>						7a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>1 23 80</b>		7b. HOUR DAY YEAR <b>12:57</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 2 1928</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>52 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Trk Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>						13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Trk Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>STACEY</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ronald B. Bozarth (son)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4391</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>													
19a. DATE OF OPERATION <b>None</b>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>P.M.</b>						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>John S. Rogers</b>						TITLE (SPECIFY) <b>Doc.</b>		MEDICAL EXAMINER		DATE SIGNED <b>Jan 23 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>						ADDRESS <b>254 E. ...</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>						23b. DATE <b>Jan 28 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trk Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Trk Park P. Geo. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Arthur Walters</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McQuinn</b>					

1992

Only use these tags: ['p>, 'b>*i>...*

Washington Newsletter



TO HOSPITAL OR ATTENDING PHYSICIAN: The I  
retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND																	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																	
CERTIFICATE OF DEATH																	
REG. NO. 8001914																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
Mehrl			Hyatt			BRANDENBURG			January 9, 1980			7:20 AM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
Male			White			Aug. 26, 1910			69 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			U.S.A.						Montgomery Co., MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Olney			Montgomery General Hospital						Conservation Aide			State of Md.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Montgomery			Damascus			YES <input type="checkbox"/> NO <input type="checkbox"/>			25008 Woodfield Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Bradley J. Brandenburg						Valeria Evaline Hyatt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
No						218-30-3663			Ethel J. Brandenburg, Item 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>UREMIA</u>																	
1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTION</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>TRANSITIONAL CANCER BLADDER</u>																	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
4 DAYS																	
1 week																	
13 yrs																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
1-4-80			CANCER OF BLADDER			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1980 to Jan 9 1980, that (I) (we) last saw the deceased alive on Jan 9 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
23a. SIGNATURE						DEGREE			23c. DATE SIGNED								
John D. Maylath						M.D.			1-9-80								
23b. PHYSICIAN'S NAME (TYPE OR PRINT)						23d. ADDRESS											
John D. Maylath						50 WEDMONTSPON DR ROCKVILLE, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			Jan. 11, 1980			Providence			Kempton, Frederick, Md.								
24. FUNERAL DIRECTOR NAME						ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Olin L. Molesworth						Damascus, Md.			JAN 14 1980			[Signature]					

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CONCLUSIONS

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FOR  
STATE  
REGISTRAR

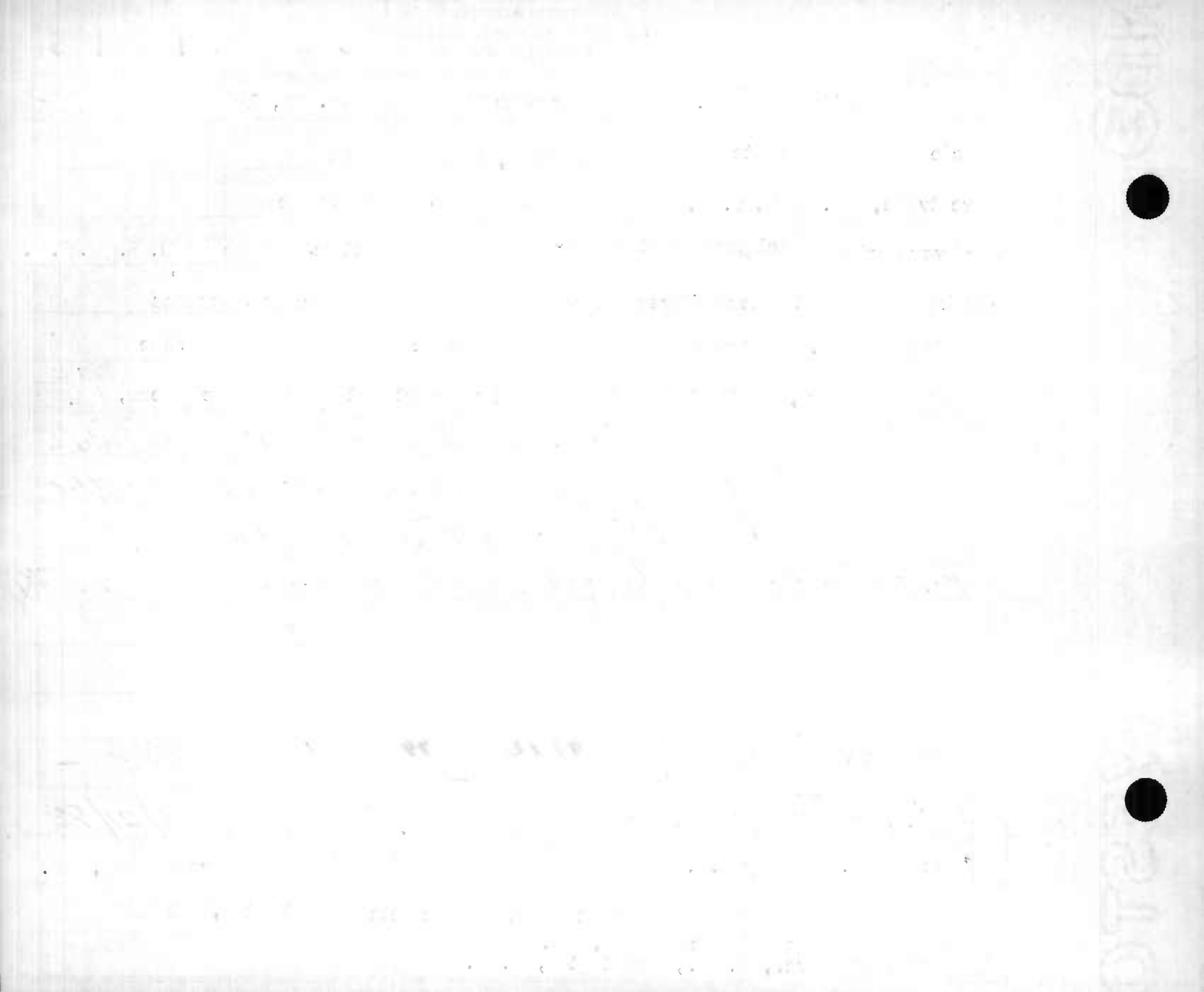
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 9 1 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY W. BRANSOM			2a. DATE OF DEATH MONTH DAY YEAR Jan. 22, 1980		2b. HOUR 7:20 PM		
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR March 6, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Forestville, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Colonel		12b. KIND OF BUSINESS OR INDUSTRY U. S. M. C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2203 Bucknell Terrace
14 FATHER'S NAME FIRST MIDDLE LAST William S. Branson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Kine				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI, WWII 578-05-2418		17 INFORMANT ADDRESS Martha Swartwout 2203 Bucknell Terr, Md. Silver Spring			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> <u>months</u> (c) <u>Arteriosclerotic heart dis.</u> <u>Yrs.</u>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Post surg from hip fr.; Chronic brain synd; Sepsis (controlled)</u>							
19a. DATE OF OPERATION <u>9/12</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Chronic brain synd</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from <u>9/12</u> 19 <u>79</u> to <u>1/21</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>1/3/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard P. Delaney</u>		DEGREE		22c. DATE SIGNED <u>1/21/80</u>		22d. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney M.D.		22f. ADDRESS 110 Carlisle Drive Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-25-80		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN STATE Arlington, Virginia	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		24b. ADDRESS 5130 Wisconsin Ave., N. W., Washington, D. C.		25a. DATE REC'D. BY REGISTRAR JAN 30 1980		25b. REGISTRAR'S SIGNATURE <u>Barry H. Creed</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

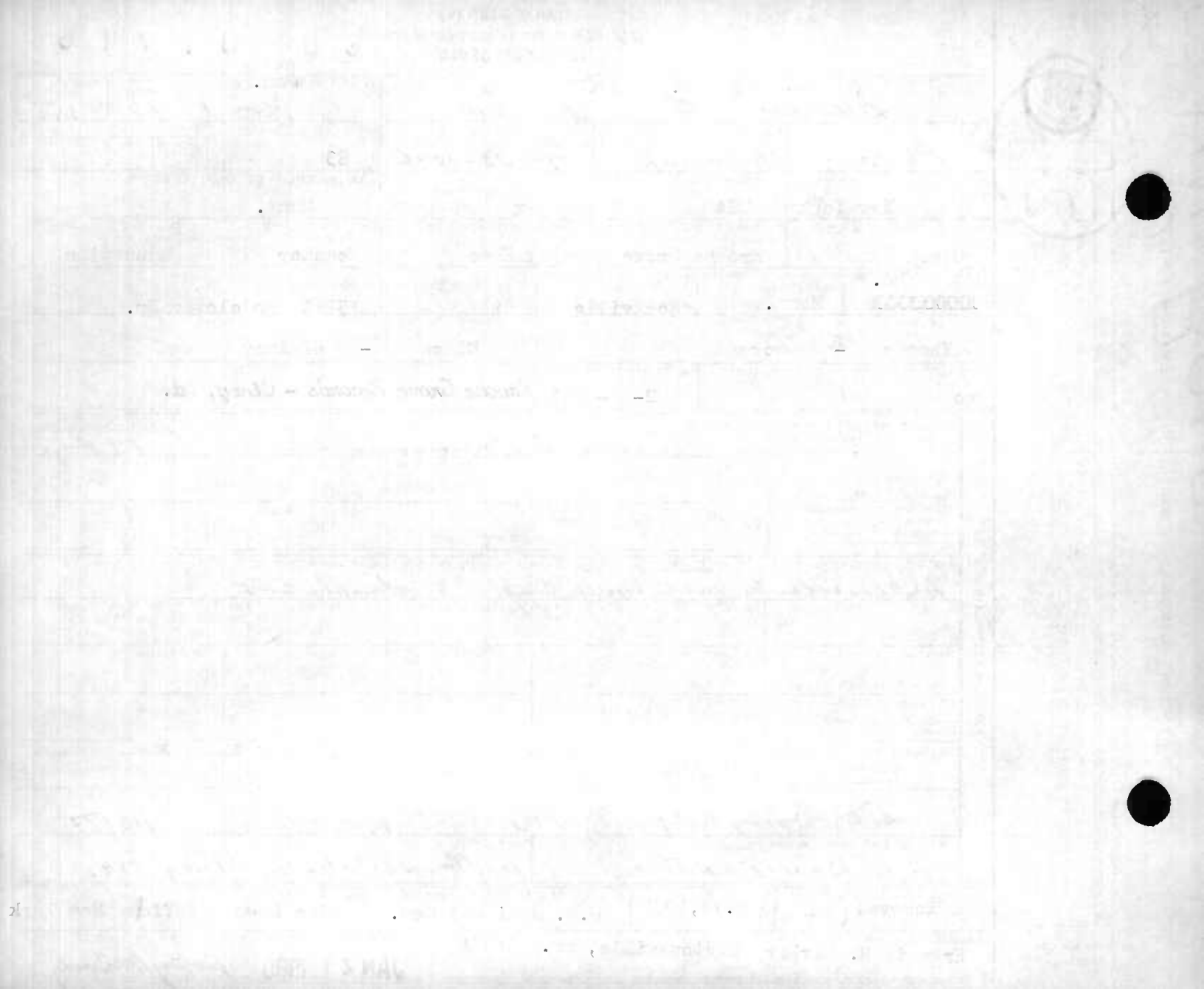


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 01916			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BLANCHE E. BROWN				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR Jan 17 80 7:15 PM			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7-28-1896		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.	
10. CITY OR TOWN OF DEATH Olney.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. <del>XXXXXX</del>		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Gorman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen - Blainey		13e. STREET ADDRESS 15212 Redclover Dr.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 102-32-4021		17. INFORMANT ADDRESS Brooke Grove Records - Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Pneumonia</u> 485- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis and ischemic disease &amp; chronic CHF</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1975</u> , to <u>Jan 17, 1980</u> , that (I) (we) lost saw the deceased alive on <u>1/15/80</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>A.D. Bonifant</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.D. BONIFANT		22e. ADDRESS 18111 Prince Philip Dr Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal (Burial)		23b. DATE Jan. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY U.S. National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pine Lawn Suffolk New York	
24. FUNERAL DIRECTOR NAME Francis H. Barber Laytonsville, Md. 20760				25a. DATE REC'D. BY REGISTRAR JAN 21 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0001917			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH E. BROWN						01-7-80						10:49PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-29-01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH X MONTGOMERY COUNTY MD.							
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Brookeville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3011 Damascus Road					
14 FATHER'S NAME FIRST MIDDLE LAST John T. Hill						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Kruhm							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. UNKNOWN		17 INFORMANT J. Fletcher Brown Same as above									
18 CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>410 -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ACUTE MYOCARDIAL EVENT</u> DUE TO OR AS A CONSEQUENCE OF <u>ASCHD.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YES.</u>										TERMINAL DISEASE OR CONDITION			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC CHF: 2 OLD MYOCARDIAL INFARCTS.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 15 1977</u> to <u>JAN 7 1980</u> , that (I) (we) lost <u>below (I) (we) did not view the body after death.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE <u>D. P. Lewis MD</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/7/80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. P. LEWIS MD						22e. ADDRESS OLNEY, MARYLAND 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION CITY OR TOWN COUNTY STATE Sunshine Mont. Md.							
24 FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760						25a. DATE REC'D. BY REGISTRAR JAN 10 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## STATE OF MARYLAND

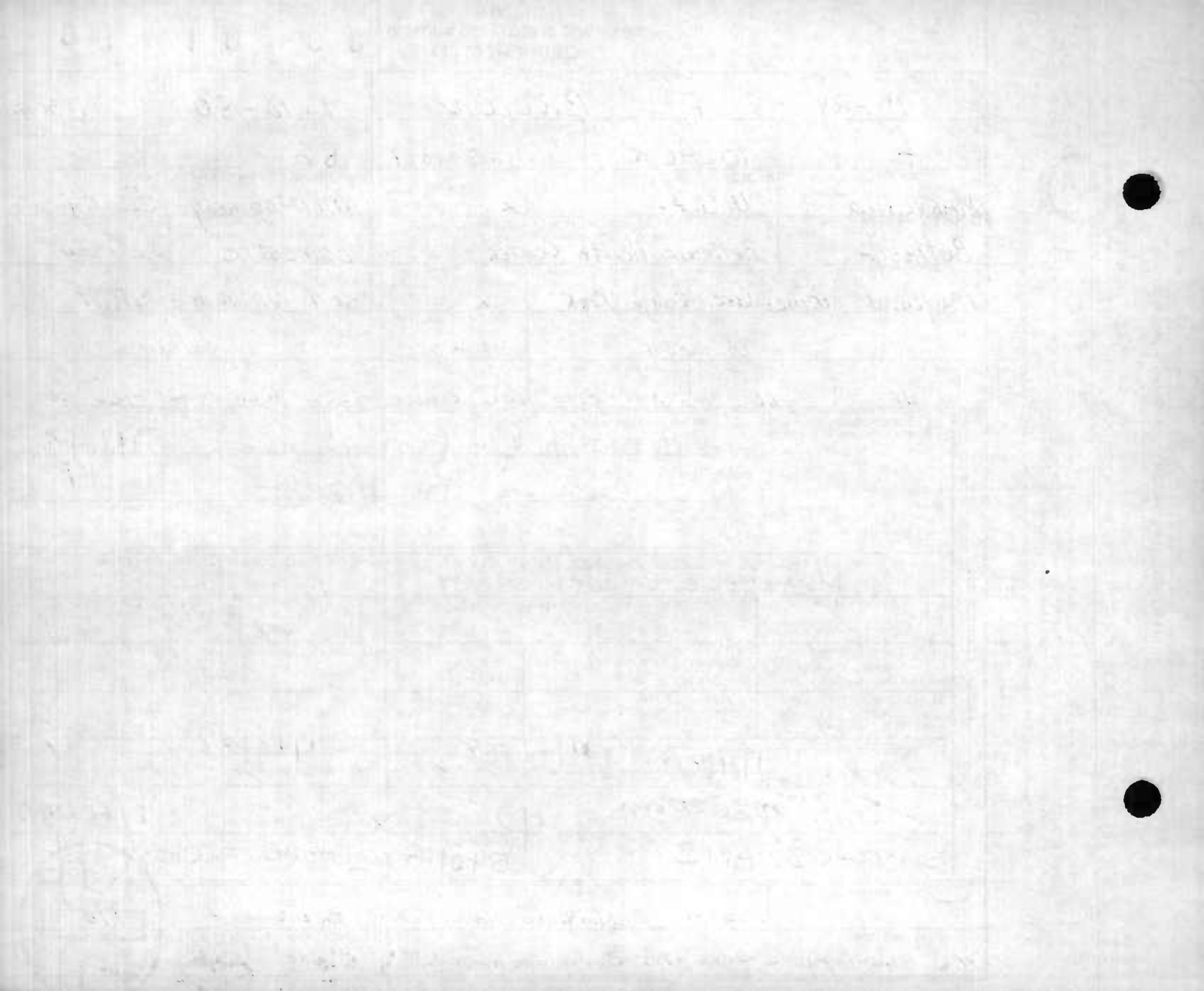
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6001918

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE F LAST BROWN			2a. DATE OF DEATH MONTH DAY YEAR 1-10-80		2b. HOUR 1:30AM		
3. SEX f		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2-28-1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN College Park	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET (UNKNOWN)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5011 NAVAHOE Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT CORR BUTLER-5302 HAMILTON ST. HYATS, MD.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic C of Carcinoma. 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Cancer Rt breast. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/16/78 1/1/50							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Metabolic encephalopathy.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/16/78, 19 to 1/10/80, 19, that (I) (we) last saw the deceased alive on 1/9/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE S.B. Goswami				DEGREE MD		22c. DATE SIGNED 1/10/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.B. GOSWAMI				22e. ADDRESS 5401 Graystone St. Chevy Chase Md 20015			
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-15-80		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NAT'L. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BERTSVILLE, M.D.	
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS				ADDRESS 4925 BURROUGHS AVE. N.E.		25a. DATE REC'D. BY REGISTRAR JAN 16 1980	
				25b. REGISTRAR'S SIGNATURE [Signature]			





BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 9 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Theodore H. BRUNS</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>21</b> YEAR <b>80</b>			2b. HOUR <b>3</b> MIN <b>15</b>						
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>1</b> YEAR <b>15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISSOURI</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda Md.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED SHOE DESIGNER (COBBLER)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SHOE CO.)</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19309 CLUB HOUSE RD. APT. 202</b>			
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>F.</b> LAST <b>BRUNS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>C.</b> LAST <b>DULLE</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>498-03-3701</b>		17. INFORMANT <b>MARGARET D. BRUNS (SAME AS 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable Cerebrovascular Accident</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Fibrosis with Respiratory Insufficiency</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>4/15</b> 19 <b>80</b> , to <b>4/21</b> 19 <b>80</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4/18</b> 19 <b>80</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did not) view the body after death.												
22b. SIGNATURE <b>Stephen Newman</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/21/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN NEWMAN</b>						22e. ADDRESS <b>19261 MONTGOMERY VILLAGE AVE., GAITHERSBURG, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-28-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONTG. MD.</b>				
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY</b> ADDRESS <b>FUNERAL HOMES P/A ROCKVILLE MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>				

Run 2

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

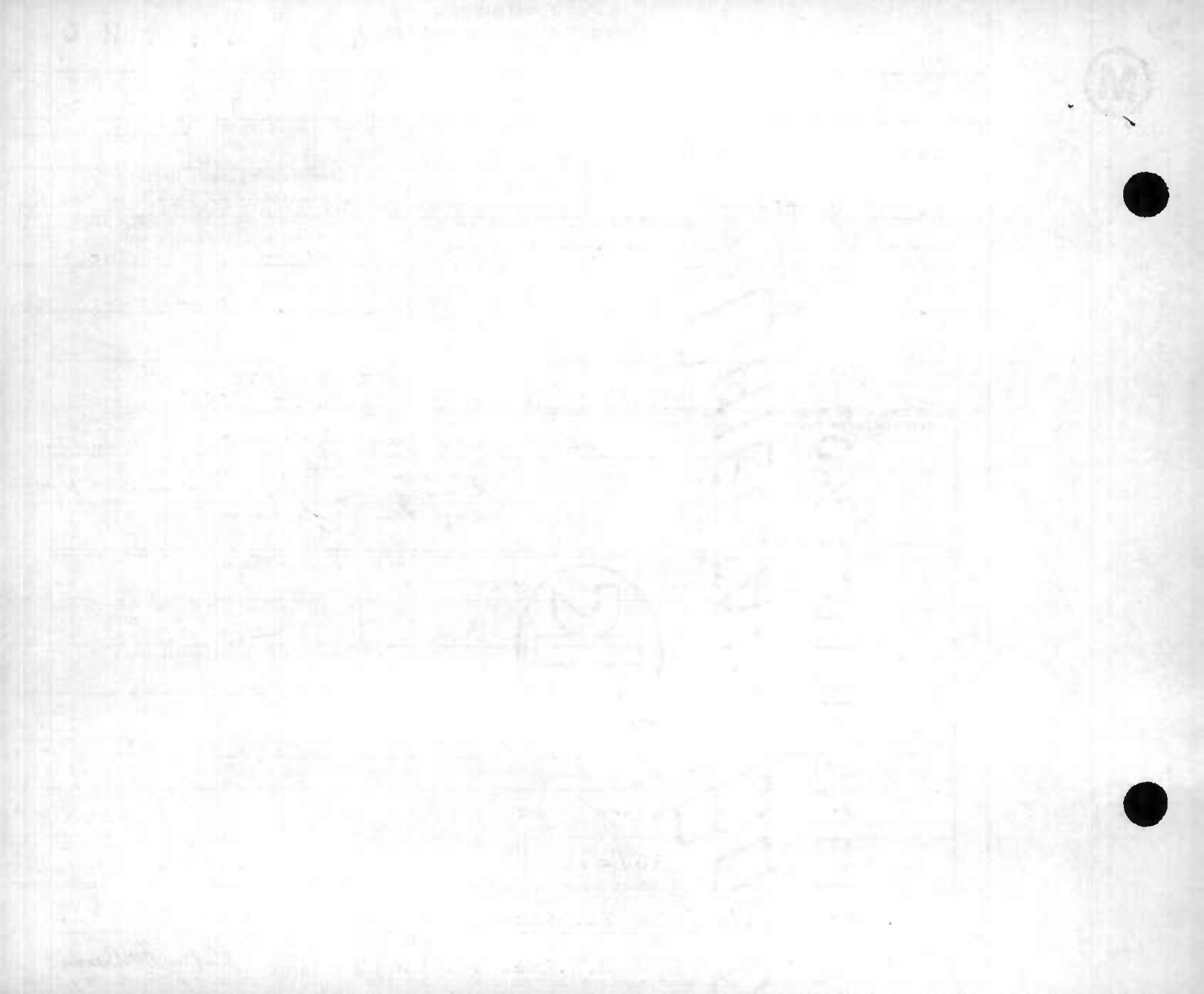
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR		REG. NO. 8001920									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EGON BUCHINGER						2a DATE OF DEATH MONTH DAY YEAR 1 24 80		2b HOUR 8:00P.M.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna Austria		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waiter		12b KIND OF BUSINESS OR INDUSTRY Hotel			
13a STATE Md.			13b COUNTY Mont		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 3429 S. Leisure World Blvd		
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b SOCIAL SECURITY NO. 144 12 3187		17. INFORMANT Same as above Mary A. Buchinger (Wife)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> <u>4/49</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary artery disease</u> <u>cardiomyopathy</u> and <u>chronic years</u> DUE TO, OR AS A CONSEQUENCE OF <u>congestive failure</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Bilateral pneumonia</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8/80</u> , 19 <u>80</u> , to <u>1/24/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/24/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Gustavo S. Belaval, MD</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUSTAVO S. BELAVAI						22e. ADDRESS Leisure world Medical Center Silver Spring, MD 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/25/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.						ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR JAN 28 1980		25b. REGISTRAR'S SIGNATURE <u>Pitney McCreedy</u>	

3203



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

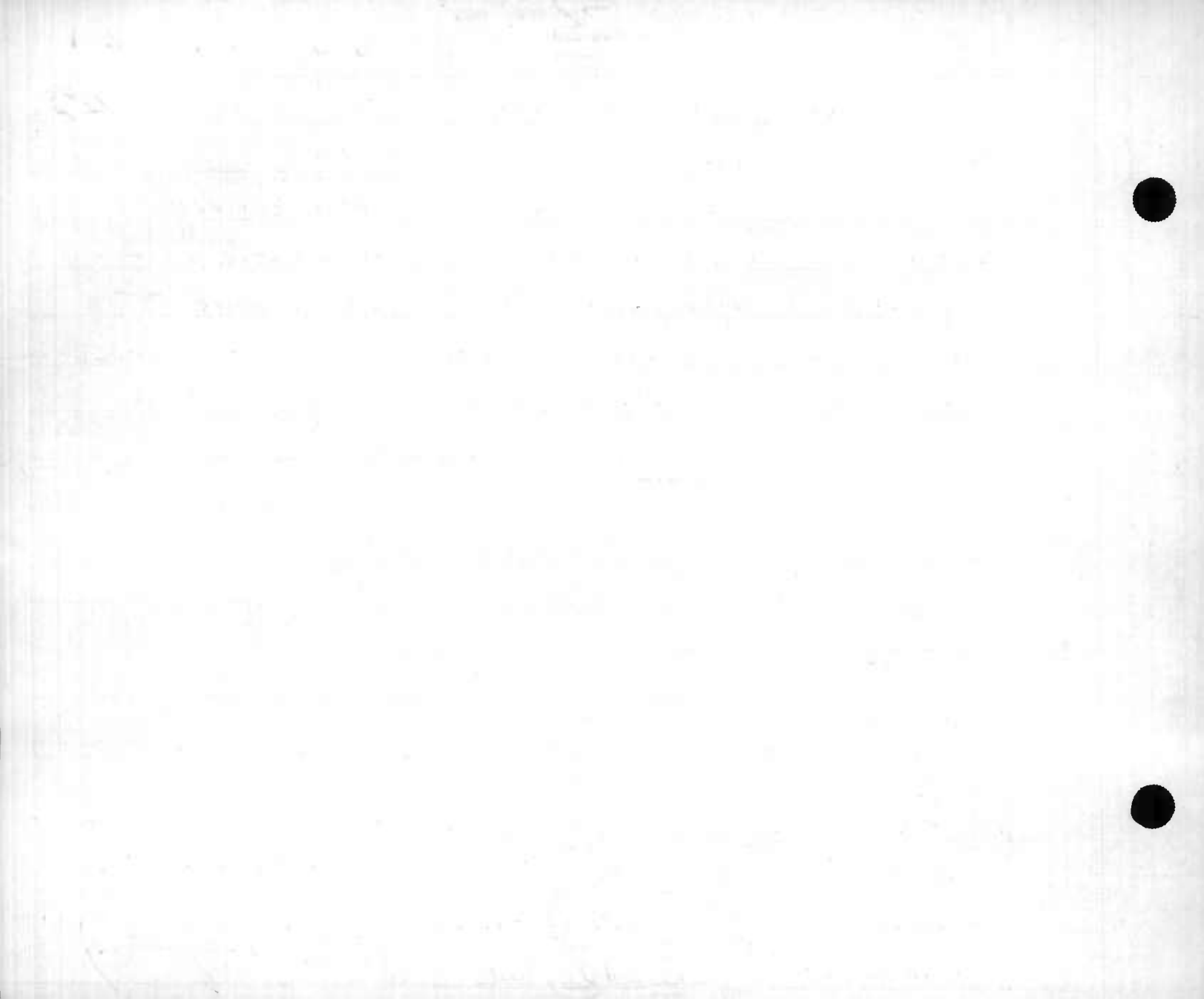
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4300 BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR		REG. NO. 80 01921								
1 DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE -		LAST BURGER		2a DATE OF DEATH MONTH DAY YEAR JAN. 13, 1980		2b. HOUR 12:40 P.M.
3 SEX Female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4213 WARNER ST		
14 FATHER'S NAME FIRST MIDDLE LAST John - DOUGHERTY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - FITZGERALD								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 163284566A		17 INFORMANT MRS. GERTRUDE Simpson		ADDRESS # 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and Septicemia 1369 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) infection DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 40 hours.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Cardiovascular Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from Dec. 13, 1979, to Jan. 13, 1980, that (b) (we) lost saw the deceased alive on Jan. 9, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) did (did not) view the body after death.										
22b. SIGNATURE Benjamin A. Furman MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-13-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin A. Furman MD		22e. ADDRESS 3720 Fremont Ave, new, md 20817								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/80		23c. NAME OF CEMETERY OR CREMATORY GTR of Heaven		23d. LOCATION CITY OR TOWN Silver Spring		COUNTY STATE MD		
24 FUNERAL DIRECTOR NAME W.W. ALTAVALL		ADDRESS 4748 WISC. AVE NW WASH DC 20016		25a. DATE REC'D BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE				





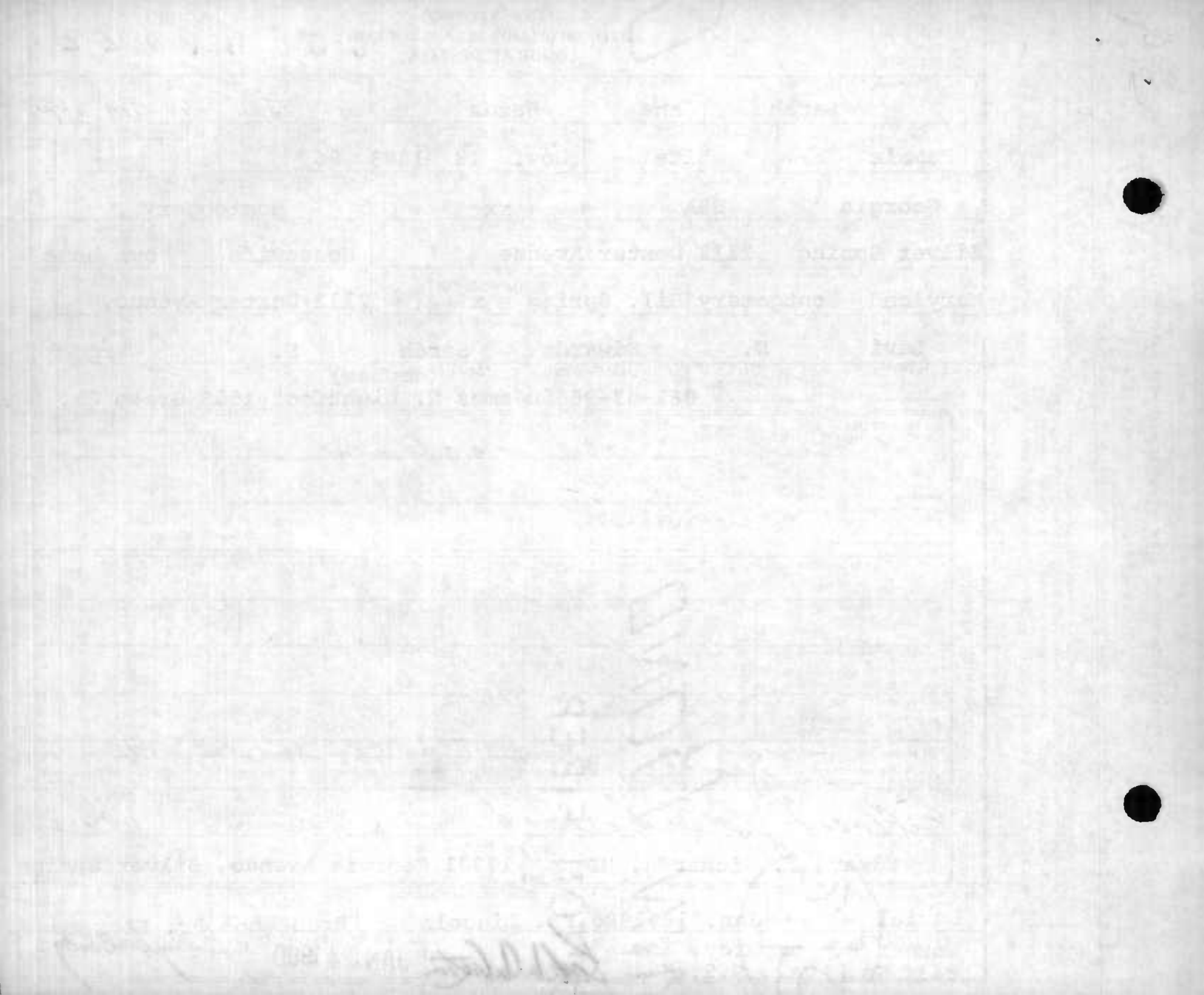
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8001922									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Sarah Jane Burns								Jan 14 1980		1:15 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7b UNDER 72 HRS	
Female		White		Nov. 18 1883		96		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		USA				Montgomery MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Silver Spring		2112 Dexter Avenue		Housewife		own home					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Montgomery		Sil. Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2112 Dexter Avenue,			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Levi D. Edwards		Sarah E. Warnock									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT (nephew) ADDRESS							
		061-03-9648D		James R. Lightfoot-1508 Grace Ch. Rd.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral Ischemia											
436- DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from Aug 9, 1957, to June 16, 1980, that (I) (we) last saw the deceased alive on Jan 3, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b SIGNATURE DEGREE										22c DATE SIGNED	
Edward J. Richards, MD										1-16-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS	
Edward J. Richards, MD										10301 Georgia Avenue, Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		Jan. 18, 1980		Ft. Lincoln		Brentwood Pr. Georges Md					
24 FUNERAL DIRECTOR										25a DATE REC'D. BY REGISTRAR	
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.										JAN 24 1980	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at 1-800-368-1234.

1 - FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 0001923	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy May Burton</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/15/80</i>		2b. HOUR <i>7:30 P.M.</i>
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 24 1932</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>47</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Brooke Grove Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>2414 Briggs Chaney Rd</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>John R. Tomlinson</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Estelle Markward</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-82-2087</i>		17. INFORMANT ADDRESS <i>Isaac Burton Above</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition</i> <i>3310</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Alzheimer's Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i> <i>5 yr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <i>36 1/15 80</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> 19 <i>80</i> , to <i>1/15</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>1/15</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above, (I) (we) (we) did not see the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>[Signature]</i>		22c. DATE SIGNED <i>1/15/80</i>	
22d. PHYSICIAN'S NAME (PRINT) <i>C. H. Ligon</i>		22e. ADDRESS <i>18111 Potomac Dr Olney MD 20852</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan 19 1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Union Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bartonsville MD</i>
24. FUNERAL DIRECTOR NAME <i>Danaedon Funeral Home</i>		24b. ADDRESS <i>MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1980</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 80 01924							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred JETTIE BURTON						2a DATE OF DEATH MONTH DAY YEAR 1 6 80		2b HOUR 4:25 P	
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 05 12 23		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 56		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a STATE MD.		13b COUNTY PG		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 8014 14th AVE #102	
14 FATHER'S NAME FIRST MIDDLE LAST Tom 1310e				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Hedbecker Nicholson 303 St. N.E.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Ernestine Bachman 303 Nicholson St. N.E., D.C.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1579 Metastasis due to DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Dec 10 19 79 to Jan 6 19 80, that (I) (we) last saw the deceased alive on Jan 6 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE MKarim				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 1-6-1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MOBARAK KARIM				22e ADDRESS 201 Landover Mall West, Landover, Md					
23a BURIAL (or CREMATION, REMOVAL)		23b. DATE 1-10-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Rd MD			
24 FUNERAL DIRECTOR NAME H.S. Washington & Sons 4925 N. 1st Bunnock Rd				25a DATE REC'D. BY REGISTRAR JAN 17 1980		25b. REGISTRAR'S SIGNATURE J. H. H. H.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		700 01925		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James H. Bushby				2a. DATE OF DEATH MONTH DAY YEAR 11/14/80		2b. HOUR 12:35 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10/20/02		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sign Painter		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Russell Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert H. Bushby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Genevieve Woodworth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 218-03-2145		17. INFORMANT ADDRESS Mr. George W. Bushby 4000 Montpelier Rd. Rockville, MD. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> 4289 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Bed Ridden</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 19 <u>75</u> to <u>present</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gregor</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregor				22e. ADDRESS 12105 Oakcrest Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/16/80		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD.			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A.				25. DATE REC'D. BY REGISTRAR 18 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			
8728 Liberty Road Randallstown, MD. 21133									



INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

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30623 COLLECTION #193



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 8001926		1. DECEASED NAME (TYPE OR PRINT) Forester Benjamin BUTLER		2a. DATE OF DEATH MONTH DAY YEAR January 4, 1980		2b. HOUR 4:00 AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9430 Holsey Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9430 Holsey Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Lawson Butler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Welsh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-16-7708		17. INFORMANT ADDRESS Emma F. Butler, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/15, 1978, to 1/4, 1980, that (I) (we) last saw the deceased alive on 12/28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Jan. 5, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D.				22e. ADDRESS 26618 Ridge Rd., Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Friendship U.M.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a. DATE RECEIVED BY REGISTRAR 1/10/80		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 80 01927   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) <i>Catherine L. Cameron</i>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 30, 1980</i>                                  |  |  |  | 2b. HOUR <i>2:35</i> AM   |  |
| 3 SEX <i>Female</i>  |  | 4 RACE <i>White</i>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <i>8-10-1913</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS.   |  | 7a. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.                                 |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH <i>Bethesda</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Ret. Practical Nurse</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE <i>Md.</i>   |  | 13b. COUNTY <i>Mont.</i>  |  | 13c. CITY OR TOWN <i>Bethesda</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <i>4914 - Montgomery Lane</i>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>John F. Cassidy</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret D. Conlon</i>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  | 16b. SOCIAL SECURITY NO. <i>-</i>   |  | 17 INFORMANT <i>Margaret (Sister)</i>   |  | ADDRESS <i>same as above</i>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>   |  |   |  |   |  |   |  |  |  | <i>2 min.</i>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypoxia</i>  |  |   |  |   |  |   |  |  |  | <i>10 hrs.</i>  |  |
| (c) <i>Emphysema</i>   |  |   |  |   |  |   |  |  |  | <i>5 years</i>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/22</i> , 19 <i>80</i> , to <i>1/30</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>1/29</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <i>J. E. D. Brennan</i>   |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED <i>1/30/80</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  |   |  | 23b. DATE <i>2-2-1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>                                |  | 23d. LOCATION CITY OR TOWN <i>Brentwood</i> COUNTY <i>Pr. Geo.</i> STATE <i>Md.</i>          |  |   |  |
| 24 FUNERAL DIRECTOR NAME <i>Nailey's F.H. Inc.</i> ADDRESS <i>Mt. Rainier, Md.</i>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <i>FEB 04 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Patricia K. Brady</i>  |  |   |  |

*[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. Some words like "John" and "London" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |  | REG. NO. 8001928  |  |  |                                   |                        |  |
|---|--|--|--|---|--|---|---|--|--|---|--|--|-----------------------------------|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS W. CAMERON</b>   |  |  |  |   |  |   |   |  |  | 2a. DATE OF DEATH MONTH <b>01</b> DAY <b>01</b> YEAR <b>80</b>  |  |  |                                   | 2b. HOUR <b>12:45p</b> |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>April</b> DAY <b>29</b> YEAR <b>1894</b>  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS                     |  |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>         |                                   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD. |  |  |   |  |  |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH <b>OLNEY, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b> |  |   |  |   |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Research biologist</b>                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Sil. Sp.</b>  |  |  |  |   |  |   |   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS <b>15300 Wallbrook Ct. #3D</b> |                                   |                        |  |
| 14. FATHER'S NAME FIRST <b>Hugh</b> MIDDLE <b></b> LAST <b>Cameron</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Moir</b> |   |   |  |  |   |  |  |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS <b>Stella B. Cameron-wife 811 Sp. Md. 20906 15300 Wallbrook Ct.</b> |   |  |  |   |  |  |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident.</b><br><b>436-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>cerebral atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arterial Hypertension</b> |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |                                   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |   |   |  |  |   |  |  |                                   |                        |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |  |  |   |  |  |                                   |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |  |                                   |                        |  |
| 22a. I certify that (s) (the hospital) attended the deceased from <b>1/1</b> , 19 <b>80</b> , to <b>1/1</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |  |  |   |  |  |                                   |                        |  |
| 22b. SIGNATURE <b>Alberto Rotsztein</b>   |  |  |  | DEGREE  |  |   |   | 22c. DATE SIGNED <b>1/1/80</b>   |  |   |  |  |                                   |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERTO ROTSZTEIN</b>  |  |  |  | 22e. ADDRESS <b>3701 Rosemont Blvd. Silver Spring Md. 20906</b>   |  |   |   |  |  |   |  |  |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |  |  | 23b. DATE <b>1-2-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>                                 |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>   |  |  |                                   |                        |  |
| 24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b> ADDRESS <b>300-4th St. N.E. Wash. D.C. 20002</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                          |  |   |  |  |                                   |                        |  |

Lee Funeral Home 300-N 4th St. W. Wash. D. C.  
20002

Cremation

1-2-50

Lee's Crematory

Washington, D. C. 20002

Hugh

Cameron

Marjaret

Moira

Md.

Montgomery Ad. sp.

x

19300 Wallbrook Ct. 2nd

Ret. Research biologist

U.S.A.

Scotland

White

Male

April 29, 1904

85

x

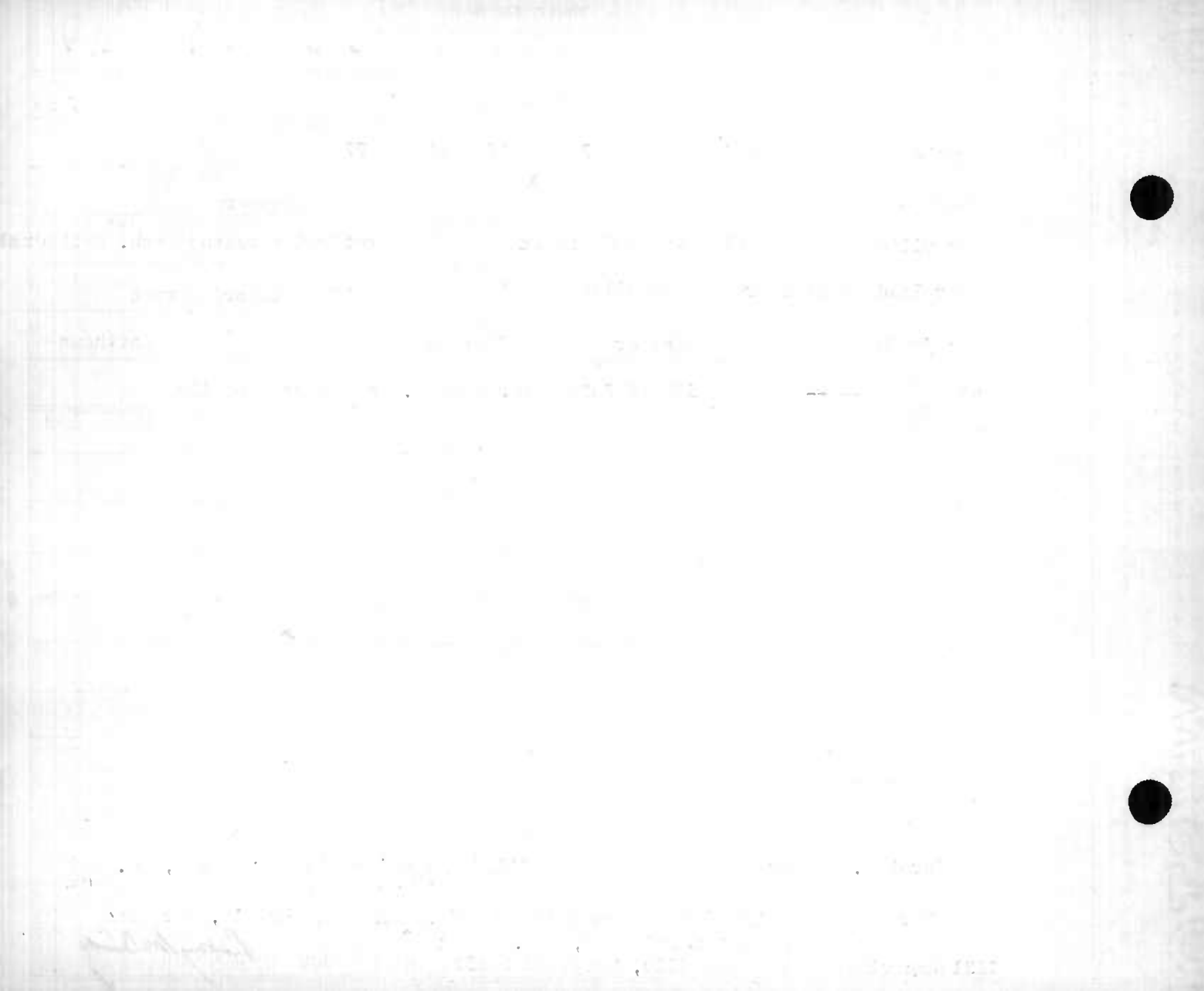
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 0 0 1 9 2 9<br>REG. NO.                    |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>JAMES H. CARTER</i>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 12 80</i>   |  | 2b. HOUR<br><i>7 PM</i>                      |  |  |  |
| 3 SEX<br><i>male</i>   |  | 4 RACE<br><i>white</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>7 26 02</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i>   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                          |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>210 Blanford Street</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><i>retired foreman</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Wash. Cathedral</i>  |  |  |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  |   |  | 13b. CITY OR TOWN<br><i>Montgomery</i>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><i>210 Blanford Street</i>  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Benjamin Carter</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Elizabeth Matthews</i>   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>578 05 7426</i>  |  | 17. INFORMANT ADDRESS<br><i>Margaret M. Carter same as 13e</i>                         |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><i>1629</i> IMMEDIATE CAUSE (a) <i>Respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Lung</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 19 <i>80</i> to <i>Jan 12</i> 19 <i>80</i> , that (I) <i>two</i> lost saw the deceased alive on <i>1/12</i> 19 <i>80</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>did not</i> (did not) view the body after death.      |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Carol L. Bender</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><i>1/13/80</i>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Carol L. Bender</i>  |  |   |  | 22e. ADDRESS<br><i>11125 Rockville Pike Rockville, Md. 20852</i>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1/16/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Memorial Park</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Rockville, Maryland</i>               |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><i>Tyson Wheeler Funeral Home, Inc.</i>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 17 1980</i>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. H. H.</i>   |  |  |  |  |  |
| 1331 Rockville Pike Rockville, Maryland 20852  |  |   |  |   |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                   |  |                | 8 0 0 1 9 3 0<br>REG. NO.                      |              |   |                |  |                           |  |
|--|--|--|--|---|--|--|-------------------|--|----------------|--|--------------|---|----------------|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Henry Carter</b>   |  |  |  |   |  |  | 2a. DATE OF DEATH |  | MONTH <b>1</b> |  | DAY <b>2</b> |   | YEAR <b>80</b> |  | 2b. HOUR <b>6:30 P.M.</b> |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>20</b> YEAR <b>20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                      |                   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |                | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |              |   |                |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                          |                   |  |                |  |              |   |                |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>     |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |                |  |              |   |                |  |                           |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Montg</b>  |  | 13c. CITY OR TOWN<br><b>Laytonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                   | 13e. STREET ADDRESS<br><b>7730 BRINK Rd.</b>   |                |  |              |   |                |  |                           |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>CARTER</b> LAST <b>CARTER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAUDE</b> MIDDLE <b>JACKSON</b> LAST <b></b>   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-8413</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MARIE CARTER (Wife) Same as 13</b>   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |                   |  |                |  |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b> |                |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                |  |              |   |                |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> , 19 <b>79</b> , to <b>1/2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.      |  |  |  |   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 22b. SIGNATURE<br><b>K. C. Brace</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  |                   | 22c. DATE SIGNED<br><b>1/2/80</b>  |                |  |              |   |                |  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kierland C. Brace</b>  |  |  |  | 22e. ADDRESS<br><b>7600 CARROLL AVE Takoma Park Md.</b>   |  |  |                   |  |                |  |              |   |                |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-5-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BROOK GROVE CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Laytonsville</b> COUNTY <b>Montg</b> STATE <b>Md.</b> |                   |  |                |  |              |   |                |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>George R. Snowden</b> ADDRESS <b>244 N. WASH. ST. Rockville, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1980</b> 25b. REGISTRAR'S SIGNATURE <b>P. R. [Signature]</b>  |  |  |                   |  |                |  |              |   |                |  |                           |  |

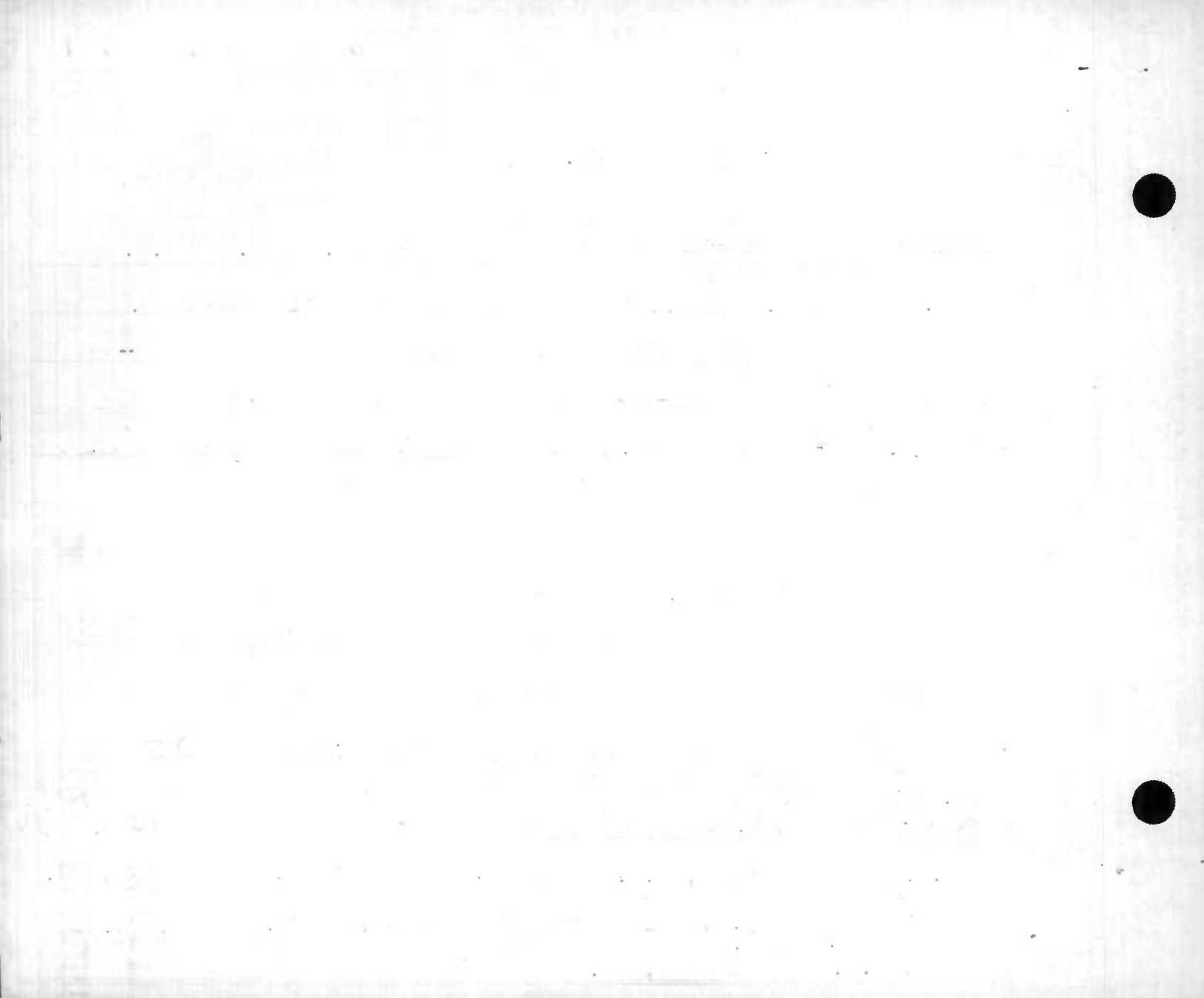


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |   |                             | REG. NO. 80 01931                                    |  |
|---|--|--|---|---|--|--|--|---|-----------------------------|--|--|
| 1- FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> George <sup>MIDDLE</sup> J <sup>LAST</sup> Chafaris |   |  |  | 2a. DATE OF DEATH <sup>MONTH</sup> 1 <sup>DAY</sup> 2 <sup>YEAR</sup> 80 |   | 2b. HOUR 1230a <sup>M</sup> |  |  |
| 3 SEX Male  |  | 4 RACE Caucasian   |   | 5. DATE OF BIRTH <sup>MONTH</sup> Oct. <sup>DAY</sup> 31, <sup>YEAR</sup> 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 57 <sup>YRS.</sup>   |  | IF UNDER 1 YEAR <sup>MONTHS</sup> <sup>DAYS</sup> <sup>HOURS</sup> <sup>MIN</sup>                                       |                             | IF UNDER 24 HRS <sup>HOURS</sup> <sup>MIN</sup>      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery <sup>MD.</sup>                               |  |   |                             |  |  |
| 10. CITY OR TOWN OF DEATH Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elect. Engr.                   |  | 12b. KIND OF BUSINESS OR INDUSTRY G.E.  |                             |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |  |   |                             |  |  |
| 13a. STATE Md.  |  | 13b. COUNTY Montg.   |   | 13c. CITY OR TOWN Rockville   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 6925 Old Stage Rd.  |                             |  |  |
| 14. FATHER'S NAME <sup>FIRST</sup> John <sup>MIDDLE</sup> <sup>LAST</sup> Chafaris  |  |  |   | 15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Dorothea <sup>MIDDLE</sup> <sup>LAST</sup> Eggart   |  |  |  |   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 062-28-5391   |   | 17. INFORMANT Digna Chafaris  |  |  |  | ADDRESS Same as 13  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1991 Un differentiated carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |  |  |  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) metastatic to liver lymph nodes liver   |  |  |   |   |  |  |  |   |                             |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |                             |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |                             |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 11, 1977, to Jan 1, 1980, that (1) (we) last saw the deceased alive on Jan 1, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death.)                                   |  |  |   |   |  |  |  |   |                             |  |  |
| 22b. SIGNATURE OF PHYSICIAN G. Bowditch Hunter, M.D.  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED Jan 2, 1980  |                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Bowditch Hunter, M.D.  |  |  |   | 22e. ADDRESS 50 W. Edmonston Dr. Rockville, Md.   |  |  |  |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE Jan. 3, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Cren.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.                                      |  |   |                             |  |  |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. ADDRESS Bethesda, Md.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR JAN 7 1980  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |   |                             |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR   |  |         |  |                  |   |                   |  |                |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                          |  |  |   |  |          |  |  | REG. NO. 01932      |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
|---|--|---------|--|------------------|---|-------------------|--|----------------|--|---|--|--------------------------|--|--|---|--|----------|--|--|---------------------|--|--|--|--|----------------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         |  |                  | FIRST MIDDLE LAST   |                   |  |                |  | 2a. DATE KNOWN OF DEATH   |  |                          |  |  | 2b. DATE ESTIMATED  |  |          |  |  | 7b. HOUR            |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| CHARLES Merile  |  |         |  |                  | CHAFIN  |                   |  |                |  | 01/09/80  |  |                          |  |  | 01/09/80  |  |          |  |  | 3:15 PM             |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  |  |   |  | 7d. HOUR |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| MALE  |  | WHITE   |  | 05/04/01         |   | 78                |  | MONTHS         |  | DAYS  |  | Jan 9 1980               |  |  |   |  | 3:15 PM  |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |  |                |  | 8. MARRIED  |  |                          |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  |  | MD.                 |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| West Virginia   |  |         |  |                  | U.S.A.  |                   |  |                |  | WIDOWED   |  |                          |  |  | MONTGOMERY  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |  |                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| BETHESDA  |  |         |  |                  | SUBURBAN HOSPITAL   |                   |  |                |  | Labor Department U.S. Gov't   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         |  |                  |   |                   |  |                |  | 13d. INSIDE CITY LIMITS?  |  |                          |  |  |   |  |          |  |  | 13e. STREET ADDRESS |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |         |  |                  |   |                   |  |                |  | 13b. COUNTY   |  |                          |  |  |   |  |          |  |  | 13c. CITY OR TOWN   |  |  |  |  |                                  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 10620 Weymouth Street |  |  |  |  |  |  |  |  |  |
| Maryland  |  |         |  |                  |   |                   |  |                |  | Montg.  |  |                          |  |  |   |  |          |  |  | Bethesda            |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |         |  |                  | 15. MOTHER'S MAIDEN NAME                                    |                   |  |                |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |                          |  |  | 16b. SOCIAL SECURITY NO.  |  |          |  |  | 17. INFORMANT       |  |  |  |  | ADDRESS                          |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| Wallace   |  |         |  |                  | Elizabeth   |                   |  |                |  | Yes   |  |                          |  |  | WWI & WWII  |  |          |  |  | 233-20-2210         |  |  |  |  | Virginia J. Chafin (Same as 13e) |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:   |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>  |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| (b) <u>Septicemia - acute cystitis</u>  |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| (c) <u>Fracture of skull laceration of Brain</u>  |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| <u>acute &amp; chronic alcoholism</u>   |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  |                |  |   |  |                          |  |  | 20. AUTOPSY?  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                  | 21b. TIME OF INJURY   |                   |  |                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                           |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  | P.M. 12-6 1979  |                   |  |                |  | Fall down stairs at home  |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |  |         |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |  |                |  | 21f. LOCATION   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
|   |  |         |  |                  | Home  |                   |  |                |  | 10620 Weymouth St Bethesda Mont. Md.  |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |                  |   |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |         |  |                  | TITLE (SPECIFY)   |                   |  |                |  |   |  |                          |  |  | DATE  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| John G. Ball  |  |         |  |                  | Deputy  |                   |  |                |  |   |  |                          |  |  | Jan 9/1980  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |                  | ADDRESS   |                   |  |                |  |   |  |                          |  |  | BETHESDA, Md  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| John G. Ball  |  |         |  |                  | 7936 Old Georgetown Road                                    |                   |  |                |  |   |  |                          |  |  |   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |                  | 23b. DATE   |                   |  |                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  |  | 23d. LOCATION   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |         |  |                  | 1-14-80   |                   |  |                |  | Arlington National  |  |                          |  |  | Arlington   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |  |                  | 25a. DATE REC'D. BY REGISTRAR                               |                   |  |                |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |  | COUNTY  |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.   |  |         |  |                  | JAN 16 1980   |                   |  |                |  | [Signature]   |  |                          |  |  | Va.   |  |          |  |  |                     |  |  |  |  |                                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |

01/09/80 3:12

CHAFIN

CHARLES

WILE WHITE 07/04/01

NO TOGHERY

SUBURBAN HOSPITAL

BETTESDA

Handwritten notes and signatures in the left margin, including a large 'X' and some illegible text.

JAN 11 1980  
JAN 11 1980



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0001933

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |   |  |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Howard King Chapman, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 3, 1980</b>             |   |  | 2b. HOUR<br><b>1:20A M</b>   |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 3, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engr.</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G.S.A.</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Montg.</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>7805 Stratford Rd.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard King Chapman, Sr.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beulah Greer</b>  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Ellinor L. Chapman</b>  |  | ADDRESS<br><b>Same as 13</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Carcinoma of Prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>5 years</b>  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/19/78</b> to <b>April 12/80</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/1/80</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Gary P. Fisher</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/3/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary P. Fisher</b>   |  |   | 22e. ADDRESS<br><b>5530 Wisconsin Ave., Chevy Chase, Md.</b>           |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Jan. 5, 1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral<br/>Homes, P.A. Bethesda, Md.</b>  |  |   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1980</b>          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>             |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8001934

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                              |  |  |
|--|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PETER GEORGE CHAPOGAS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 - 15 - 80</b> |   | 2b. HOUR<br><b>1 30 A.M.</b> |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 28 1928</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8750 Georgia Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Asst. Chief</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.D.A.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |   | 13b. COUNTY<br><b>Montgomery</b>  |                              | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Peter Chapogas</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kanella K. Kapelas</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW11 082-20-9111</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Irene Chapogas, Wife. Same as item 13.</b>   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN TUMOR -</b><br>2396<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 mos</b>  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-12</b> 19 <b>79</b> to <b>1-15</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-26</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><i>Allen M. Mondzac</i>  |  |   |   | 22c. DATE SIGNED<br><b>Jan 15, 1980</b>   |                              | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen M. Mondzac</b>   |  |
| 22e. ADDRESS<br><b>1145 - 19th St., N. W., Washington, D. C.</b>   |  |   |   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/17/1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisconsin Avenue, N. W.</b><br><b>Washington, D. C. 20016</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |                              |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

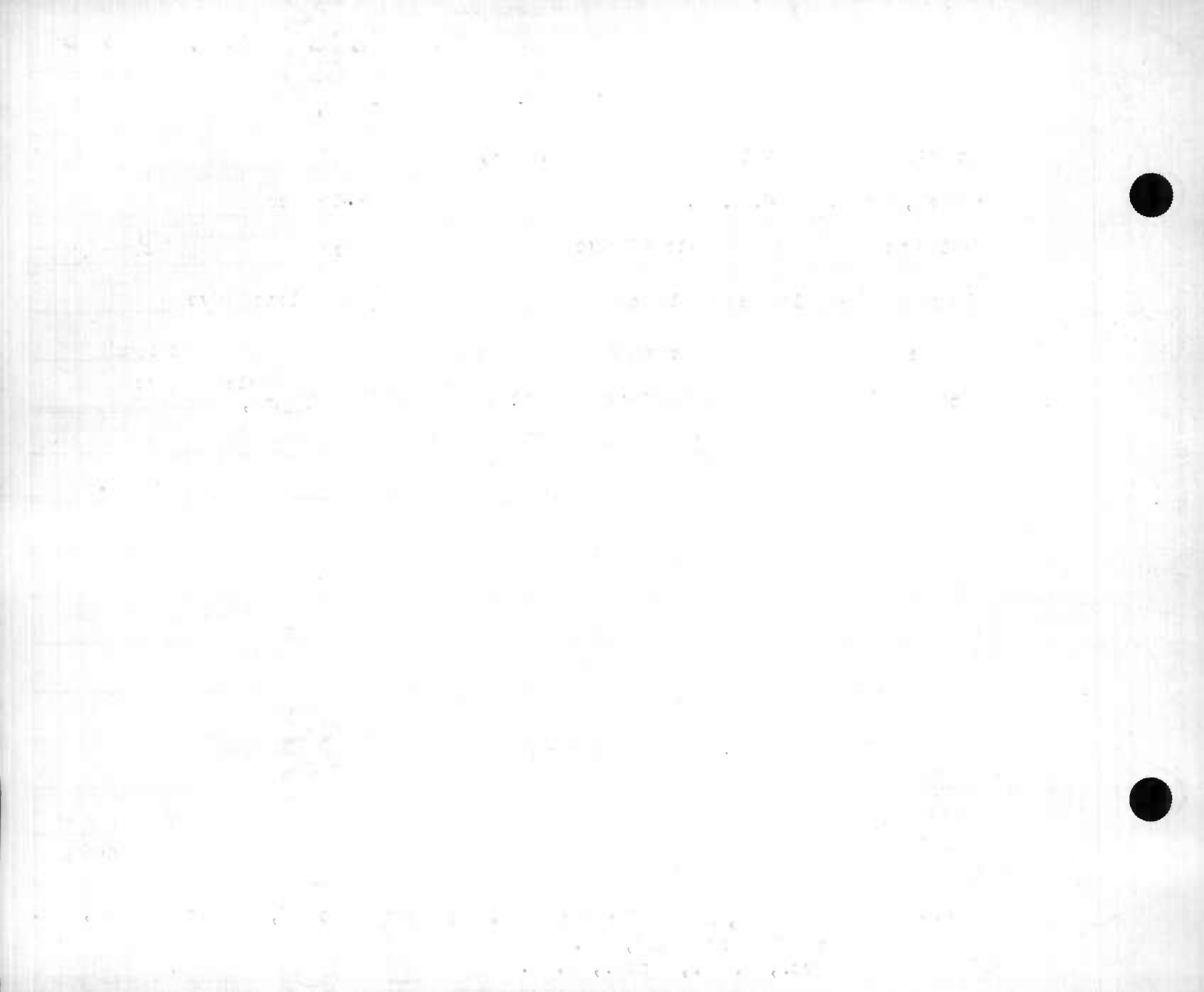


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 8001935   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>Doris Chepuras</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 30, 1980</b>  |  | 2b. HOUR <b>8:00A</b> M  |  |  |  |
| 3 SEX <b>female</b>   |  | 4 RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 24, 1905</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                                    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lowell, Mass.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Potomac</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8604 Chateau Drive</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Printing-Book-binding</b> |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE <b>Maryland</b>   |  | 13b. CITY OR TOWN <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Potomac</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>8604 Chateau Drive</b>                  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Chepuras</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Stathouli</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WW11 578-18-0564</b>   |  | 17 INFORMANT ADDRESS <b>Catherine Vaniglio 8604 Chateau Drive Potomac, Maryland</b>   |  |   |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b><br><b>8 months</b> |  |  |  |   |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/79</b> , 19____, to <b>1/30/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/19/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>J. Cooke</b> MD   |  |  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>1/30/80</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jevelyn Cooke</b>  |  |  |  |   |  | 22e. ADDRESS <b>10900 Conn Ave, Kensington Maryland</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Feb 2, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>George Wash. Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, Prince Georges, Md.</b>   |  |   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 03 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>  |  |  |  |  |  |
| 5130 Wisconsin Ave., N. W., Wash., D. C.  |  |  |  |   |  |   |  |   |  |  |  |  |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 0001936

1 - FOR  
STATE  
REGISTRAR

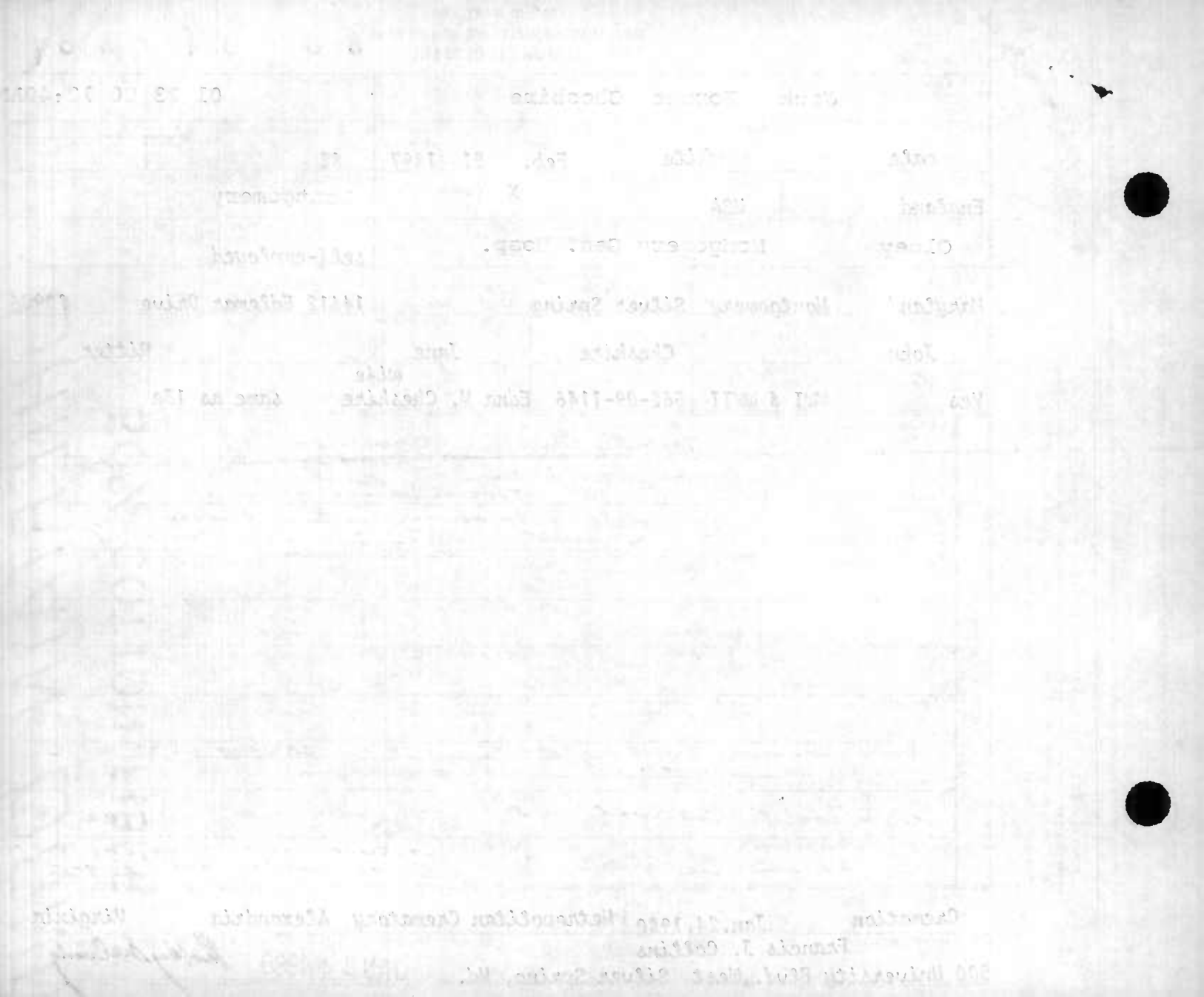
|   |  |   |   |  |                        |   |  |
|---|--|---|---|--|------------------------|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Jack Horace Cheshire</b>  |  |   | 2a DATE OF DEATH MONTH <b>01</b> DAY <b>23</b> YEAR <b>80</b> |  | 2b HOUR <b>12:40AM</b> |   |  |
| 3 SEX <b>male</b>   |  | 4 RACE <b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>Feb.</b> DAY <b>21</b> YEAR <b>1897</b>   |                        | 6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b><br>YRS MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery Gen. Hosp.</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>self-employed</b>  |                        | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Maryland</b> 13b COUNTY <b>Montgomery</b> 13c CITY OR TOWN <b>Silver Spring</b>   |  |   |   | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        | 13e STREET ADDRESS <b>14612 Edlemar Drive</b> 20906   |  |
| 14 FATHER'S NAME<br>FIRST <b>John</b> MIDDLE LAST <b>Cheshire</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jane</b> MIDDLE LAST <b>Ritter</b>  |                        |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WWI &amp; WWII</b>  |   | 17. INFORMANT <b>wife</b> ADDRESS <b>same as 13e</b>   |                        | 17. INFORMANT <b>Edna M. Cheshire</b>   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Probable Dissecting aneurysm of</b><br><b>4410</b> DUE TO, OR AS A CONSEQUENCE OF <b>aorta - rupture day</b><br><b>to arteriosclerosis of aorta</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary artery disease</b><br><b>2 recent myocardial infarcts</b><br>(c) <b>hypertension</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours.</b> |  |   |   |  |                        | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                        |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                        |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>August</b> 19 <b>79</b> to <b>23 January</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>23 January</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                        |   |  |
| 22b. SIGNATURE<br><b>Gustavo S. Belaval, MD</b>   |  |   |   | DEGREE<br><b>MD</b>  |                        | 22c. DATE SIGNED<br><b>1/23/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GUSTAVO S. BELAVAL</b>  |  |   |   | 22e. ADDRESS<br><b>Leisure World Medical Center</b><br><b>Silver Spring, Md 20906</b>  |                        |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |  | 23b. DATE<br><b>Jan. 24, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>  |                        | 23d. LOCATION<br>CITY OR TOWN <b>Alexandria</b> COUNTY <b>Virginia</b> STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., West Silver Spring, Md.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>  |                        | 25b. REGISTRAR'S SIGNATURE<br><b>Rita McCreedy</b>  |  |

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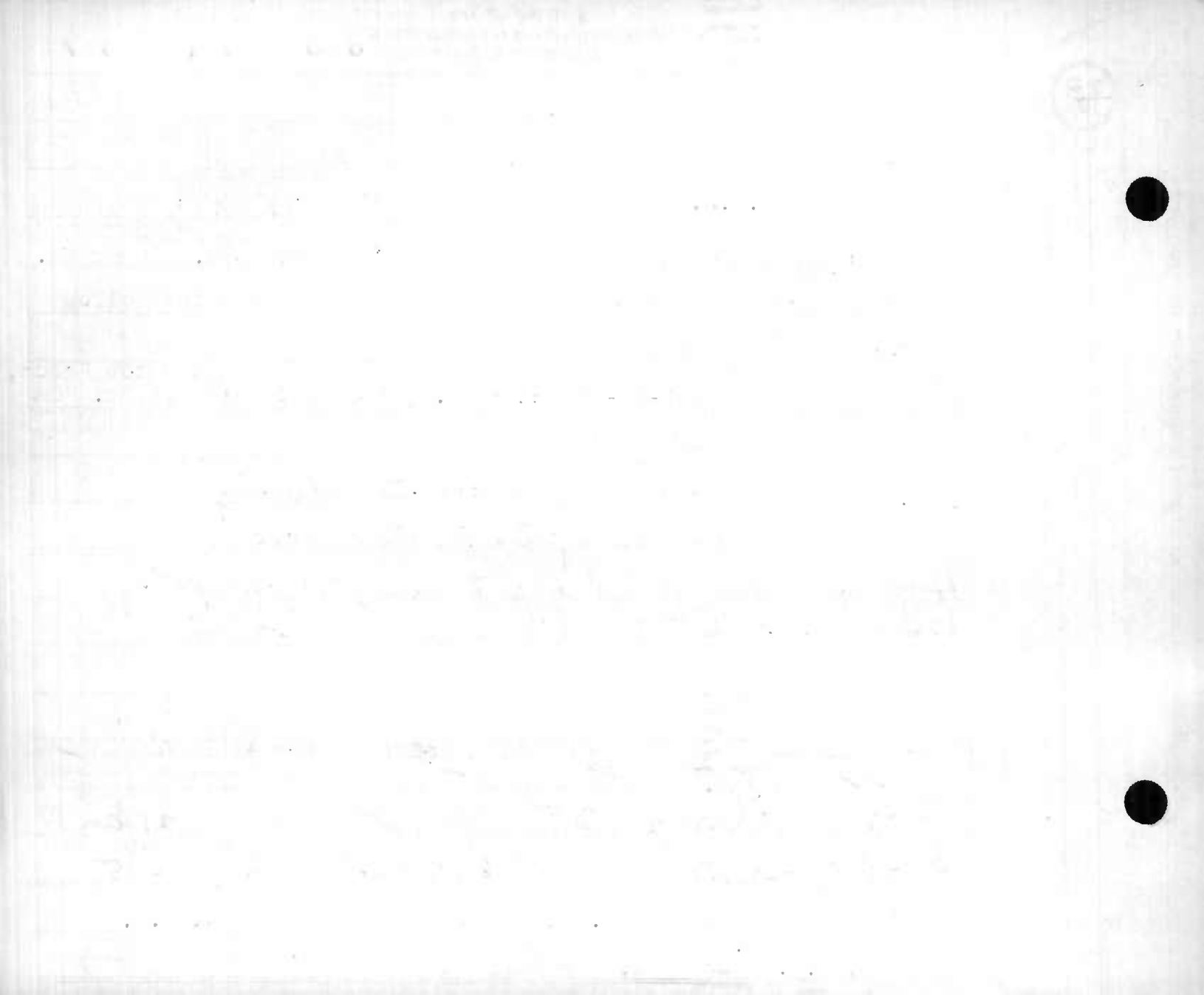


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8001937  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-80 3:15 A.M.   |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John C. Chiao   |  |  |  |   | 3. SEX Male  |  |  |   |  |   |  |
| 4. RACE oriental   |  |  |  |   | 5. DATE OF BIRTH MONTH DAY YEAR May 7, 1940  |  |  |   |  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.  |  |  |  |   | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China   |  |  |   |  |   |  |
| 8. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH Bethesda   |  |  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |  |  |   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Spec.   |  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY Singer Co.   |  |  |   |  |   |  |
| 13a. STATE Maryland  |  |  |  |   | 13b. CITY OR TOWN Howard   |  |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Chiao  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Ho   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no   |  |  |  |   | 16b. SOCIAL SECURITY NO 057-34-6418  |  |  |   |  |   |  |
| 17. INFORMANT ADDRESS Huntington Beach, CA   |  |  |  |   | 18. HENRY C. CHIAO 8952 SAILPORT DR. CA  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Shock  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal and other bleeding  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Hepatitis B with cirrhosis.   |  |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypersplenism, portal hypertension, coagulopathy.  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATED OPERATION 12 Dec 79   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrointestinal hemorrhage  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from Nov 30, 1980, to Jan 21, 1980, that (II) last saw the deceased alive on Jan 20, 1980, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did not) visit the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE R. Eric Alving, M.D.  |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED 21 Jan 80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. ERIC ALVING   |  |  |  | 22e. ADDRESS 3816 INVERNESS DR., 20015 Chevy Chase, MD  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  |  | 23b. DATE 1/22/80   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. |   |  |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey   |  |  |  | ADDRESS Homes, P.A. Bethesda, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 28 1980   |  | 25b. REGISTRAR'S SIGNATURE History McCreedy   |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |             |  |                                    |   |   |  |                     | REG. NO. 8001938   |  |
|--|--|--|-------------|--|------------------------------------|---|---|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |             |  | 2a. DATE OF DEATH                  |   | MONTH DAY YEAR  |  | 2b. HOUR            |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Anna CHILTON</i>   |  |  |             |  | 2a. DATE OF DEATH                  |   | MONTH DAY YEAR  |  | 2b. HOUR            |  |  |
| 3 SEX  |  | 4 RACE   |             | 5 DATE OF BIRTH  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)                                |   | IF UNDER 1 YEAR  |                     | IF UNDER 24 HRS  |  |
| Female   |  | White  |             | Oct 10, 1896   |                                    | 83 YRS  |   | MONTHS DAYS  |                     | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |                     |  |  |
| Latvia   |  | USA  |             |  |                                    | Montgomery Co. MD.  |   |  |                     |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |             |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                     |  |  |
| Rockville  |  | Hebrew Home of Greater Washington  |             |  |                                    | Garment Worker  |   | Ladies Clo.  |                     |  |  |
| 13a. STATE   |  |  | 13b. COUNTY |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |  |
| Maryland   |  |  | Montgomery  |  | Bethesda                           |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6812 Marbury Road   |  |  |
| 14. FATHER'S NAME  |  |  |             |  | 15. MOTHER'S MAIDEN NAME           |   |   |  |                     |  |  |
| FIRST MIDDLE LAST  |  |  |             |  | FIRST MIDDLE LAST                  |   |   |  |                     |  |  |
| Morris (unknown)   |  |  |             |  | Bayla (unknown)                    |   |   |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |             |  | 16b. SOCIAL SECURITY NO.           |   | 17. INFORMANT ADDRESS   |  |                     |  |  |
| No   |  |  |             |  | 099-05-9902D                       |   | Hebrew Home Records   |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)  |  |  |             |  |                                    |   |   |  |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |             |  |                                    |   |   |  |                     |  |  |
| IMMEDIATE CAUSE (a) <i>Aspx</i>  |  |  |             |  |                                    |   |   |  |                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |             |  |                                    |   |   |  |                     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |             |  |                                    |   |   |  |                     |  |  |
| 1b) <i>Pneumonia; UTI</i>  |  |  |             |  |                                    |   |   |  |                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |             |  |                                    |   |   |  |                     |  |  |
| 1c) <i>aspiration (possible)</i>   |  |  |             |  |                                    |   |   |  |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |             |  |                                    |   |   |  |                     |  |  |
| <i>organic brain syndrome</i>  |  |  |             |  |                                    |   |   |  |                     |  |  |
| 19a. DATE OF OPERATION   |  |  |             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |   |   | 20a. AUTOPSY?  |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |             |  |                                    |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |             | 21b. TIME OF INJURY  |                                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                     |  |  |
|  |  |  |             | HOUR A.M. MONTH DAY YEAR   |                                    |   |   |  |                     |  |  |
|  |  |  |             | P.M. 19  |                                    |   |   |  |                     |  |  |
| 21d. INJURY OCCURRED   |  |  |             | 21e. PLACE OF INJURY   |                                    |   |   | 21f. LOCATION  |                     |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |             | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                    |   |   | STREET CITY OR TOWN COUNTY STATE   |                     |  |  |
| 22a. I certify that <i>none</i> (this hospital) attended the deceased from <i>2/7</i> , 19 <i>77</i> , to <i>1/12</i> , 19 <i>80</i> , that <i>we</i> (we) lost <i>saw</i> the deceased <i>glance</i> above <i>the head</i> (did not view the body after death). |  |  |             |  |                                    |   |   |  |                     |  |  |
| 22b. SIGNATURE   |  |  |             | DEGREE   |                                    |   |   | 22c. DATE SIGNED   |                     |  |  |
| <i>Maisha Wallace MD</i>   |  |  |             | ASSOC MEDICAL STAFF  |                                    |   |   | 1/13/80  |                     |  |  |
|  |  |  |             | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>                             |                                    |   |   |  |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |             | 22e. ADDRESS   |                                    |   |   |  |                     |  |  |
| MARS HA T. WALLACE MD  |  |  |             | 6121 Montrose Rd Rockville Md  |                                    |   |   |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |   | 23d. LOCATION  |                     |  |  |
| Burial   |  |  | 1-15-80     |  | Mt. Lebanon Cemetery               |   |   | Glendale, New York   |                     |  |  |
| 24. FUNERAL DIRECTOR   |  |  |             |  | 25a. DATE REC'D. BY REGISTRAR      |   |   | 25b. REGISTRAR'S SIGNATURE   |                     |  |  |
| NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike   |  |  |             |  | Rockville, Md.                     |   |   | IAN 17 1980  |                     |  |  |

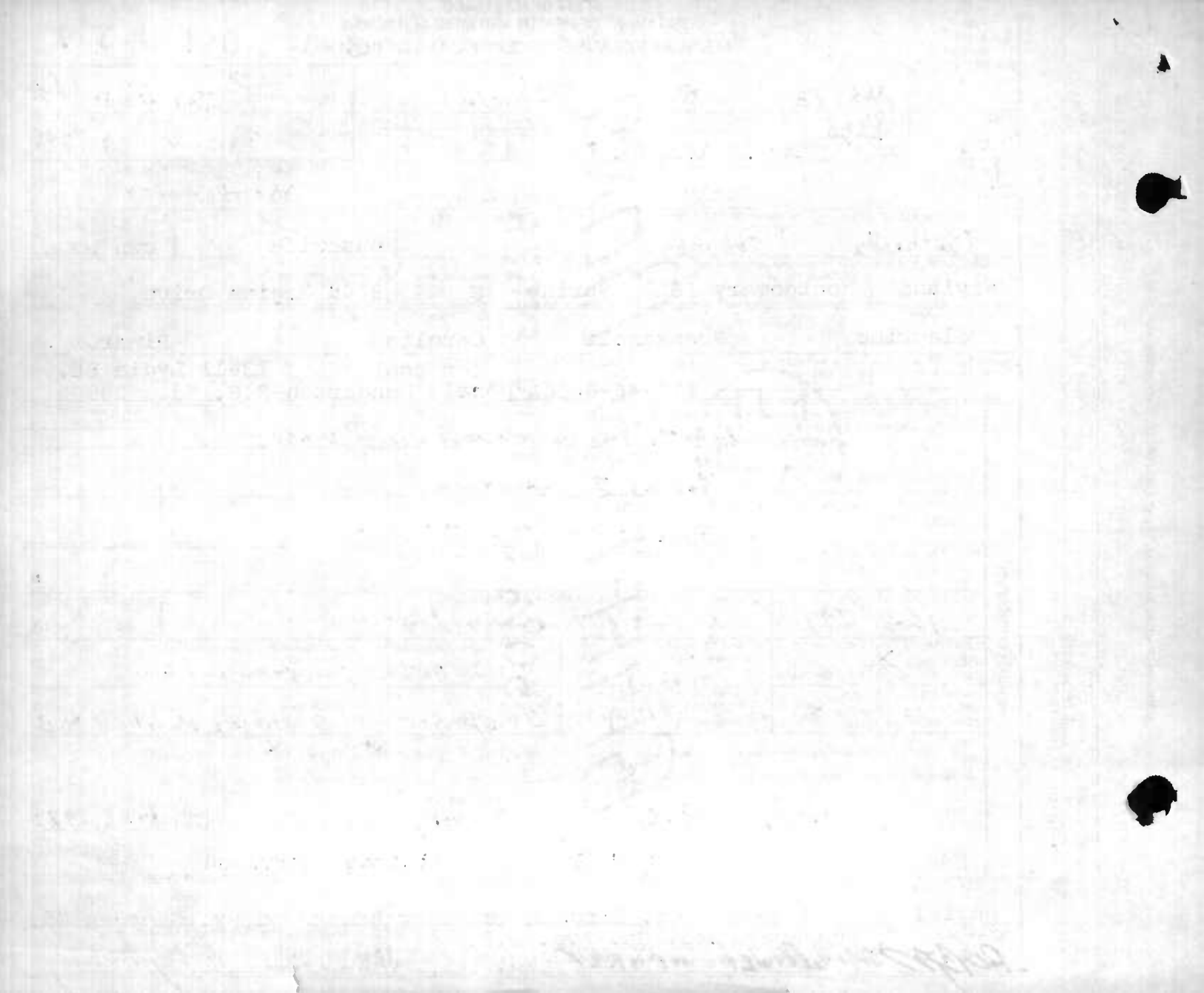
8-11-08



1908

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR  |         | STATE OF MARYLAND<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |                       | REG. NO. 01939   |                  |
|---|---------|--|-----------------------|--|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST MIDDLE LAST  |                       | 2a. DATE KNOWN OF DEATH ESTI- MATED  |                  |
| Maria R. Chiodi   |         |  |                       | MONTH DAY YEAR 4 19 80   |                  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)     | IF UNDER 1 YR.   | IF UNDER 24 HRS. |
| xx  | White   | MONTH DAY YEAR May 19 1891                                   | LAST BIRTHDAY 88 YRS. | MONTHS DAYS  | HOURS MIN.       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                 |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |
| Italy   |         | Italy  |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION     |                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                  |
| Bethesda  |         | Suburban   |                       | Housewife  |                  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |         | 13a. STREET ADDRESS  |                       | 13b. CITY LIMITS?  |                  |
| own home  |         | 3209 Regina Drive,   |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                     |                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                  |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST  |                       | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |                  |
| Pelegriano Scanzaroli   |         | Carolina Pinardi   |                       | -----  |                  |
| 16b. SOCIAL SECURITY NO.  |         | 17. INFORMANT  |                       | ADDRESS  |                  |
| 578-46-6056A  |         | (gr-son) Donald Henderson-S.S. Md.                           |                       | 13411 Lydia St., 20906   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |                       |  |                  |
| PART I DEATH WAS CAUSED BY:   |         |  |                       |  |                  |
| IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>  |         |  |                       |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                       |  |                  |
| (b) <u>Renal Insufficiency</u>  |         |  |                       |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                       |  |                  |
| (c) <u>Fracture of Left Hip.</u>  |         |  |                       |  |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |                       |  |                  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |                       | 20. AUTOPSY?   |                  |
| 12-21-79  |         | Repair of Fracture of Left Hip                               |                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                  |
|   |         | HOUR P.M. MONTH DAY YEAR P.M. 12 18 1979                     |                       | Fall on bathroom floor of nursing home.  |                  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                       | 21f. LOCATION  |                  |
| Nursing Home  |         | Nursing Home   |                       | STREET CITY OR TOWN COUNTY STATE   |                  |
|   |         | Crosstener Ln. Bethesda Mont. Md.                            |                       |  |                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |                       |  |                  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |                       | DATE SIGNED  |                  |
| John G. Ball  |         | M.D. Deputy  |                       | Jan 6, 1980  |                  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |                       |  |                  |
| John G. Ball, DME   |         | Bethesda, Maryland   |                       |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                       | 23c. NAME OF CEMETERY OR CREMATORY   |                  |
| Burial  |         | 1-8-80   |                       | Ft. Lincoln Cemetery   |                  |
| 23d. LOCATION   |         | 23e. DATE REC'D. BY REGISTRAR                                |                       | 23f. REGISTRAR'S SIGNATURE   |                  |
| CITY OR TOWN COUNTY STATE   |         | JAN 10 1980  |                       | History, Inc. County   |                  |
| Brentwood Pr. Georges Md.   |         |  |                       |  |                  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR                                |                       | 25b. REGISTRAR'S SIGNATURE   |                  |
| Walter E. Pumphrey, 8434 Ga. Ave. S.S. Md.  |         |  |                       |  |                  |





|   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
|---|--|------------------------------|--|--|--|--|--|--|--|--------------------------------------|--|--|--|-----|--|--|--|----------|--|---------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST                        |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  |                                      |  | MONTH  |  | DAY |  | YEAR   |  | 2b. HOUR |  |                                       |  |  |  |
| MAN Bong Cho  |  |                              |  |  |  |  |  | 1-10-80  |  |                                      |  |  |  |     |  |  |  | 11:40 M  |  |                                       |  |  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                      |  | IF UNDER 1 YEAR  |  |     |  | IF UNDER 24 HRS.                             |  |          |  |                                       |  |  |  |
| Male  |  | Korean                       |  | Dec. 21, 1903  |  |  |  | 76 YRS.  |  |                                      |  | MONTHS   |  |     |  | DAYS   |  |          |  |                                       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| Seoul, Korea  |  | Korea                        |  |  |  |  |  |  |  | Montgomery.                          |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |     |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |          |  |                                       |  |  |  |
| Takoma Park,  |  |                              |  | Washington Adventist Hospital  |  |  |  |  |  |                                      |  | Retired.   |  |     |  |  |  |          |  |                                       |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | 13d. INSIDE CITY LIMITS?                     |  |          |  | 13e. STREET ADDRESS                   |  |  |  |
| 13a. STATE  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | 13b. COUNTY                                  |  |          |  | 13c. CITY OR TOWN                     |  |  |  |
| Maryland.   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | Montgomery.                                  |  |          |  | Bethesda                              |  |  |  |
| 14. FATHER'S NAME   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | 15. MOTHER'S MAIDEN NAME                     |  |          |  |                                       |  |  |  |
| Soo Bok Cho.  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | Ssii   |  |          |  | Kim.                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | 16b. SOCIAL SECURITY NO.                     |  |          |  | 17. INFORMANT                         |  |  |  |
| No.   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | 219-78-4521                                  |  |          |  | Soon I.C.S. Kim. 3861 No. Oriole Ave. |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |                                       |  |  |  |
| IMMEDIATE CAUSE (a) inanition,  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung cancer  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  |                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |     |  |  |  |          |  |                                       |  |  |  |
|   |  |                              |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |     |  |  |  |          |  |                                       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              |  | 21b. TIME OF INJURY  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
|   |  |                              |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
|   |  |                              |  | P.M. 19  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 21d. INJURY OCCURRED  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  | 21f. LOCATION  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from June 19 79, to Jan 10 80, that (1) was lost saw the deceased alive on Jan 9 80, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was dead (did not view the body after death). |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 22b. SIGNATURE  |  |                              |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                      |  | 22c. DATE SIGNED   |  |     |  |  |  |          |  |                                       |  |  |  |
| D.J. HAIDAK   |  |                              |  | MD   |  |  |  |  |  |                                      |  | 1/10/80  |  |     |  |  |  |          |  |                                       |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              |  | 22e. ADDRESS   |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| D.J. HAIDAK   |  |                              |  | 6521 Belcrest Rd; Hyattsville  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                                      |  | 23d. LOCATION  |  |     |  |  |  |          |  |                                       |  |  |  |
| Cremation.  |  |                              |  | Jan 14, 1980   |  |  |  | Ft. Lincoln.   |  |                                      |  | Bladensburg Rd. P. G. Co                                       |  |     |  |  |  |          |  |                                       |  |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| William W. H. 254 Capital St NW   |  |                              |  | JAN 14 1980  |  |  |  | R. J. B. B. B.   |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |
| Washington D.C. 20012   |  |                              |  |  |  |  |  |  |  |                                      |  |  |  |     |  |  |  |          |  |                                       |  |  |  |

Male  
 Korean  
 Seoul, Korea  
 Washington Adventist Hospital, retired.  
 Maryland, Montgomery, Bethesda  
 4521 East-West Highway  
 No. 200 NOK Cho.  
 219-78-4521 Soon KOB. Kim. 3861 No. Oxford Ave.  
 Chicago, Ill.  
 Kim.

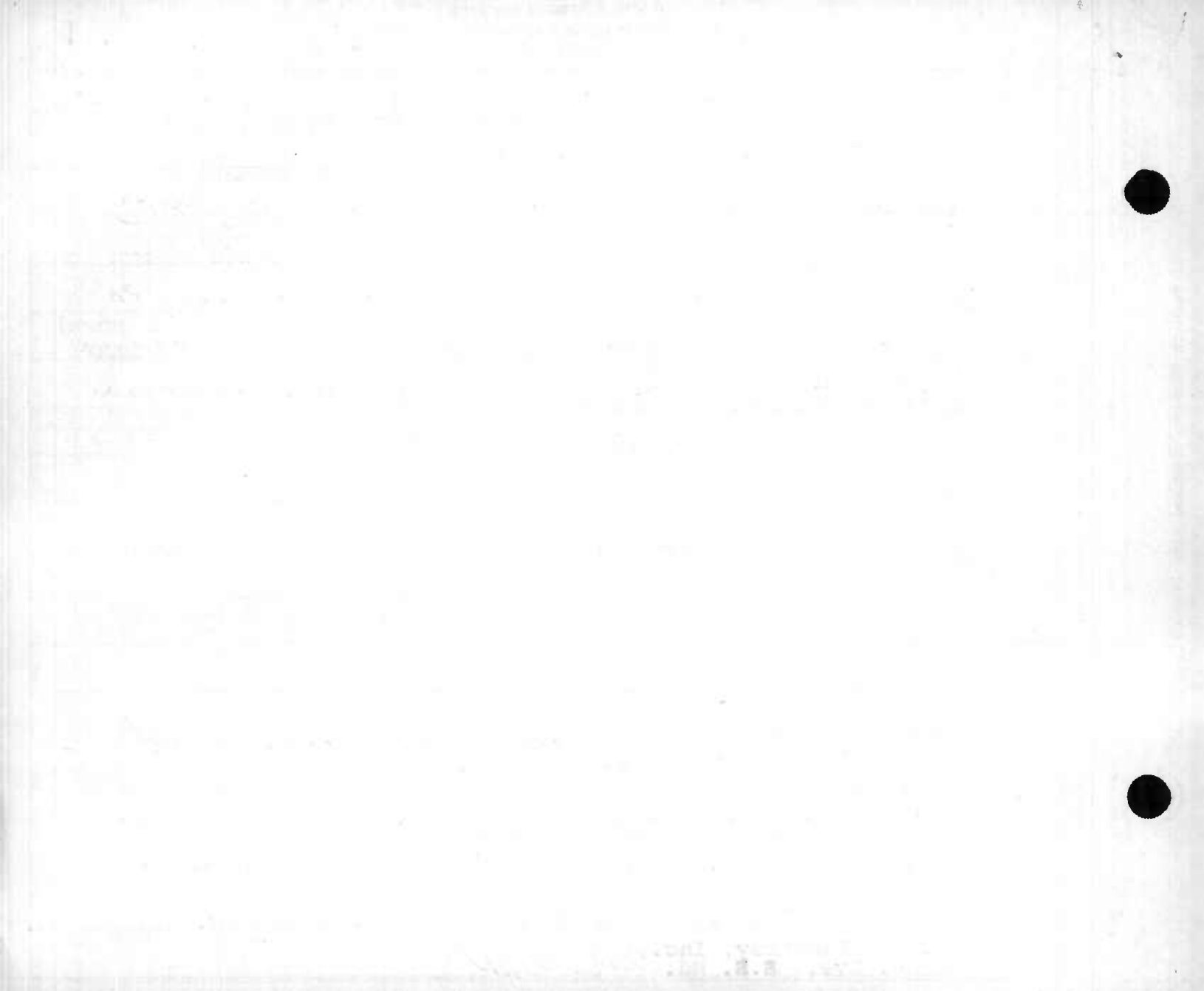
Cremation. Jan 14, 1980 Ft. Lincoln. Richmond B. V. G. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                     |  | REG. NO. 8001941                             |  |
|--|--|--|--|--|--|---|--|---------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  | 2b. HOUR            |  | 2c. AM                                       |  |
|  |  | Helen S. Christopoulos   |  |  |  | 1/26/80   |  | 430                 |  | A.M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                              |  |
| Female   |  | White  |  | MONTH DAY YEAR   |  | 91  |  | MONTHS DAYS         |  | HOURS MIN.                                   |  |
|  |  | XXXXXX   |  | 11 14 88   |  | 91 YRS  |  |                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |  |  |
| GREECE   |  | USA  |  |  |  | Montgomery County   |  |                     |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |  |  |
| Silver Spring  |  | Holy Cross Hospital  |  | Housewife  |  | own home  |  |                     |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. COUNTY  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS |  |  |  |
| MD.  |  | MONT.  |  | KENSINGTON   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 9812 Old Spring Rd. |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |                     |  |  |  |
| SOCRATES   |  | STAMOS   |  | ELENI  |  | (unknown)   |  |                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |  |  |
| No   |  | Unobtainable   |  | SON - JAMES  |  | 9812 OLD SPRING RD  |  |                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |                     |  | 37 HRS                                       |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis  |  |  |  |  |  |   |  |                     |  |  |  |
| 4340   |  |  |  |  |  |   |  |                     |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                     |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |                     |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                     |  |  |  |
| (c)  |  |  |  |  |  |   |  |                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |                     |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                     |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |                     |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY              |  | STATE  |  |
|  |  |  |  |  |  |   |  |                     |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/54 to 1-26-80, that (I) (we) lost saw the deceased alive on 1-25-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                     |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                     |  |  |  |
| James C Mandes M.D.  |  |  |  |  |  | 1-26-80   |  |                     |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                     |  |  |  |
| James C Mandes MD  |  | 1631 16TH ST N.W. WASH DC  |  |  |  |   |  |                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY              |  | STATE  |  |
| Burial   |  | 1-28-80  |  | Ft. Lincoln  |  | Brentwood Pk.   |  | Georges Md.         |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |  |  |
| Warner E. Pumphrey, Inc.   |  | JAN 31 1980  |  | [Signature]  |  |   |  |                     |  |  |  |
| 8434 Ga. Ave., S.E. Md.  |  |  |  |  |  |   |  |                     |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MIRELLA RINA CIMINI  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 19, 1980                           |   | 2b. HOUR<br>10:30 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 26, 1961  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>18 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash., D. C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NIH Clinical Center, Bethesda, MD |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Worker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Advertising  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Pr. George's   | 13c. CITY OR TOWN<br>Cheltenham   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>10410 Frank Tippet Rd   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Giorgio Cimini  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Santi   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>579-96-4644   |   | 17. INFORMANT<br>ADDRESS<br>10410 Frank Tippet Rd.<br>Mrs. Anna Cimini (Mother) Cheltenham Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ewing's Sarcoma</u>  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 seconds<br>1 minute<br>19 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <u>December 25, 1979</u> to <u>January 19, 1980</u> , that (x) (we) last saw the deceased alive on <u>January 19, 1980</u> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Robert T. Maguire</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>1/20/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ROBERT T. MAGUIRE</u>   |  | 22e. ADDRESS<br><u>National Institutes of Health<br/>Clinical Center, Bethesda, MD 20205</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>1/23/80</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resurrection Cemetery</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Clinton Pr. George Md.</u>                     | 23e. DATE REC'D. BY REGISTRAR<br><u>JAN 22 1980</u>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>George P. Kalas Funeral Home</u>   |  | ADDRESS<br><u>6160 Oxon Hill Rd.<br/>Oxon Hill, Md.</u>   |   | 25. REGISTRAR'S SIGNATURE<br><u>Litney McCurdy</u>  |  |

March, 1910

Office Worker

Mr. George's

Send

Answer

Clinton

George

10110 Frank Street N.E.  
Washington, D.C.

No

10110

10110 Frank Street N.E.

Washington, D.C.

10110 Frank Street N.E.

10110

Frank

Restoration Company  
Clinton, N.Y.  
10110 Frank Street N.E.  
Washington, D.C.

George P. Hays Funeral Home  
Oxon Hill, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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2900

DHMM-16 20M  
(VRA 15, 4) 7/78FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8001943

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>AUSREE E CLARK  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 31 80 |  |  | 2b. HOUR P/<br>12:12 M   |  |
| 3 SEX<br>F  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 20 91   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>US Govt.  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Sil. Spring   |  | 13d. STREET ADDRESS<br>8505 Springvale Road,   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Eldridge   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Dowlar   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>219-42-4714   |  | 17 INFORMANT (daughter)<br>Julia A. Coffin-Annadale, Va. 22203   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic small cell carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (b) of left lung &<br>DUE TO, OR AS A CONSEQUENCE OF (c) spinal cord compression<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (d), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from April 19 79, to 1-31 19 80, that (I) (we) lost saw the deceased alive on 1-31 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>JASON GEIDER, M.D.  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>1-31-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JASON GEIDER, M.D.   |  | 22e. ADDRESS<br>8830 CAMERON STREET<br>SILVER SPRING, MD. 20910  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 4, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Georges Md.  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 06 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Jeffrey McCreedy   |  | 26. ADDRESS<br>8434 Ga. Ave., S.S. Md.   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|--|---|--|---|--|
| FOR<br>1 - STATE REGISTRAR  |  |   |  |  |  |   |  |  |   |  |   |  |
| REG. NO. 8001944  |  |   |  |  |  |   |  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Loraine M. CLEMENT</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>26</b> YEAR <b>80</b>  |  |  | 2b. HOUR <b>6:25 a</b> M                              |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>1</b> YEAR <b>1880</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>99</b> YRS   |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>        |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD   |  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>S.S. Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Harland Nursing Home</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>teacher ret.</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>education</b> |  |   |  |
| 13a. STATE <b>D.C.</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Washington</b>  |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS<br><b>3900 Conn. Ave. N.W.</b>    |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Walter</b> MIDDLE <b>McFarlan</b> LAST <b>McFarlan</b>  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Petrie</b>   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>579-60-6989</b>   |  | 17. INFORMANT<br><b>886 Severn Ave.</b><br><b>Walter M. Fallon Edgewater, Md.</b>   |  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Prior CEREBROVASCULAR ACCIDENT</b> |  |   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |   |  |
| 22a. I certify that (I <del>the hospital</del> ) attended the deceased from <b>January 26, 1980</b> , to <b>January 26, 1980</b> , that (I <del>we</del> ) last saw the deceased alive on <b>JANUARY 9, 1980</b> and that in (my <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I <del>we</del> ) did not view the body after death. <b>(DR. CIOFFI)</b>   |  |   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Barry Hecht</b> MD   |  |   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>1/26/80</b>                    |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRY HECHT</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>10620 GEORGIA AVENUE SILVER SPRING, MD 20962</b>   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>Burial</b>  |  |   |  | 23b. DATE<br><b>1/29/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>D.C.</b> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b><br><b>Bethesda, Maryland</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 05 1980</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hilary McCreedy</b>  |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
|--|--|--|--|--|--|--|--|--|--|----------------|--|--|--|---------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8001945   |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH                            |  | MONTH          |  | DAY  |  | YEAR    |  | 2b. HOUR |  |
| William L. clerics   |  |  |  |  |  |  |  | 1  |  | 16             |  | 80   |  | 9:40 AM |  |          |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  | 7 UNDER 1 YEAR                               |  | 8 UNDER 24 HRS |  |  |  |         |  |          |  |
| Male   |  | White  |  | Apr. 18, 1911  |  | 68   |  | MONTHS                                       |  | DAYS           |  | HOURS  |  | MIN     |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |  |  |                |  |  |  |         |  |          |  |
| Wash., D. C.   |  | USA  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | Montgomery   |  |  |  |                |  |  |  |         |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |                |  |  |  |         |  |          |  |
| Takoma Park  |  | Washington Adventist Hospital  |  | Taxi Cab Driver-Retired  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS                          |  |                |  |  |  |         |  |          |  |
| Md.  |  | P.G.   |  | Upper Marlboro   |  | NO <input type="checkbox"/>                                    |  | 9025 Florin Way                              |  |                |  |  |  |         |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| Louis  |  | Clerico  |  | Catherine  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |                |  |  |  |         |  |          |  |
| No   |  | \$79-16-2607   |  | Darlene Pugh, Daughter, Same as Above  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)  |  | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                |  |  |  |         |  |          |  |
| 1991   |  | Terminal carcinoma with metastasis   |  |  |  |  |  | 1979   |  |                |  |  |  |         |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)  |  |  |  |                |  |  |  |         |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                |  |  |  |         |  |          |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                |  |  |  |         |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |                |  |  |  |         |  |          |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  |  |  | STREET   |  | CITY OR TOWN   |  | COUNTY                                       |  | STATE          |  |  |  |         |  |          |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 4/28/78  |  | 19   |  | to   |  | 1/16/80                                      |  | 19             |  | that (I) (we) last saw the deceased alive on |  | 1/16/80 |  | 19       |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |  |  |                |  |  |  |         |  |          |  |
|  |  | MD   |  | 1/16/80  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| OSOTH  |  | LEKABU MD  |  | 7425 Arlington Rd, Beltsville  |  |  |  |  |  |                |  |  |  |         |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |  |                |  |  |  |         |  |          |  |
| Burial   |  | 1-19-80  |  | Ft. Lincoln Cem.   |  | Brentwood, P.G., Maryland                                      |  |  |  |                |  |  |  |         |  |          |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                |  |  |  |         |  |          |  |
|  |  | JAN 23 1980  |  |  |  |  |  |  |  |                |  |  |  |         |  |          |  |



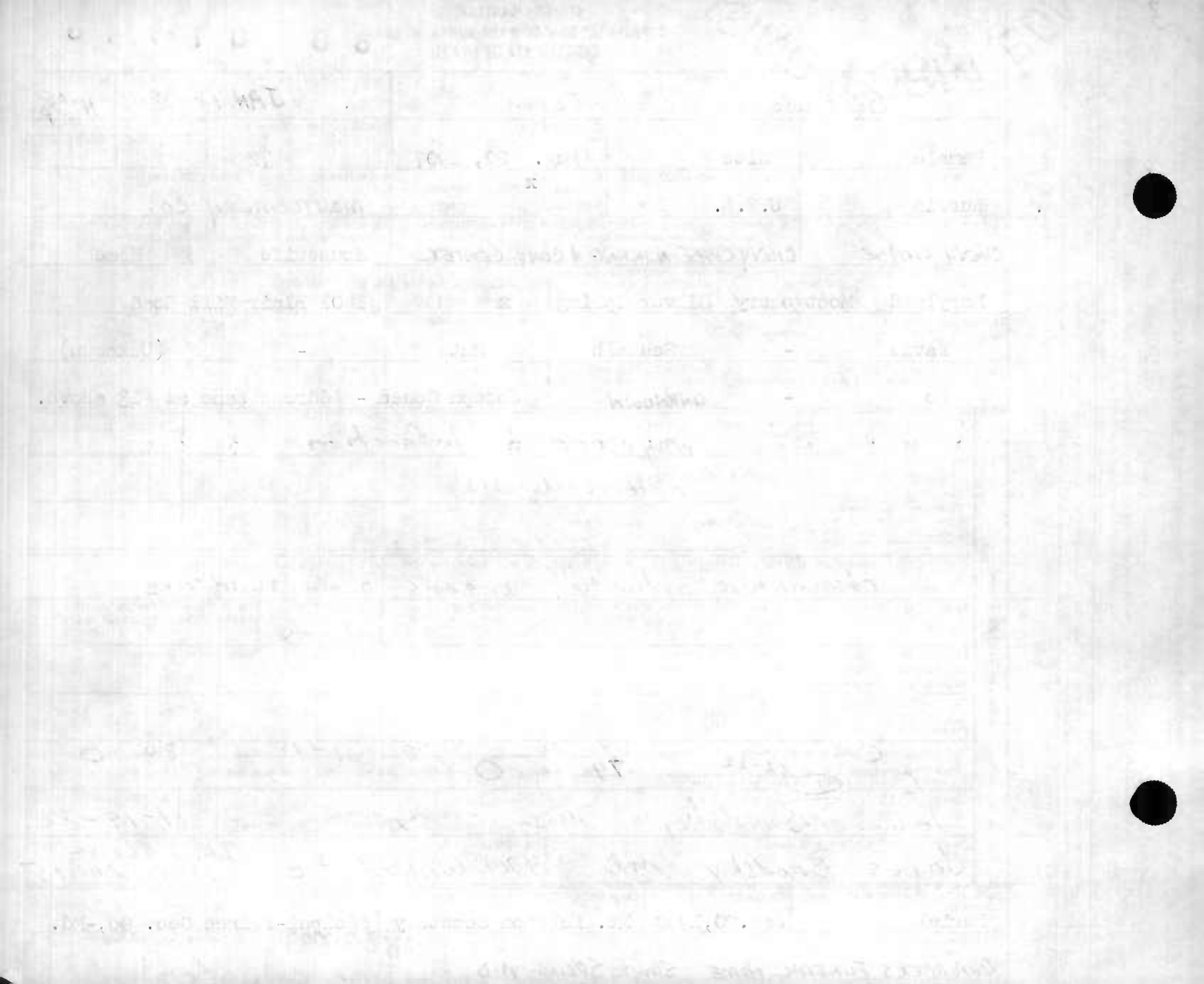
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 8001946                       |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Gertrude Cohen</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN. 18 80</b>   |  | 2b. HOUR<br><b>11:05 PM</b>            |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 20, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>72 YRS</b>            |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | 8. IF UNDER 24 HRS<br>HOURS MIN        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO. MD.</b>                 |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVY CHASE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHEVY CHASE NURSING &amp; CONV. CENTER</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>Maryland Montgomery Silver Spring</b>   |  |   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13f. STREET ADDRESS<br><b>1401 Blair Mill Road</b>                                |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>David - Schwalb</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth - (Unknown)</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>UNKNOWN</b>   |  | 17. INFORMANT ADDRESS<br><b>Joseph Cohen - Address same as #13 above.</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>rheumatoid arthritis, organic brain syndrome</b>   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10-20</b> , 19 <b>79</b> , to <b>1-18</b> , 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>12-22</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James Brodsky MD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>1-19-80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Brodsky MD</b>  |  | 22e. ADDRESS<br><b>4701 Willard Ave Chevy Chase Md. 20015</b>   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 20, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Adelphi-Prince Geo. Co., -Md.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>CHAMBERS FUNERAL HOME</b>   |  |   |  | ADDRESS<br><b>SILVER SPRING, MD</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 23 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>7</b> |  |











TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 8001948  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HARRISON CLYDE COLE   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 16 80                                    |  | 2b. HOUR<br>7:40PM   |  | M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 26 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS                                      |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY, MD.                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>OLNEY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MONTGOMERY GENERAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired miner |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>coal  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland  |  |   |  | 13b. COUNTY Montgomery  |  | 13c. CITY OR TOWN Gaithersburg   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>18730 Walkers Choice Road  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ezra Garland Cole   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Verna Suttle  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes   |  |   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW II 236 10 9798   |  | 17. INFORMANT ADDRESS<br>Sevella Cole same as 13e                              |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>cerebrovascular accident</u>   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 min<br>2 wks<br>1 month   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Diabetes mellitus, coronary insufficiency</u>   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>73</u> to <u>January 16</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>January 16</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Robert Millman</u>  |  |   |  | DEGREE<br>M.D.  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/16/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Millman, M.D.  |  |   |  | 22e. ADDRESS<br>15E Deer Park Dr Gaithersburg, Md 20760   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>1/19/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Tyson Wheeler Funeral Home, Inc<br>1331 Rockville Pike Rockville, Md. 20852   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry H. H. H.</u>  |  |   |  |



North Carolina  
State  
Department of Transportation  
Division of Motor Vehicle  
Registration  
and  
Title  
Taxes  
and  
Fees  
The following information is for your information only.  
It is not intended to be used as a legal document.  
For more information, please contact the Division of  
Motor Vehicle Registration and Title Taxes and Fees.  
Your cooperation is appreciated.

State of North Carolina  
Division of Motor Vehicle  
Registration and Title  
Taxes and Fees  
1997

Cleared by Dr. John Rogers, Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death.

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Item #16a Film G539 1/29/80 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

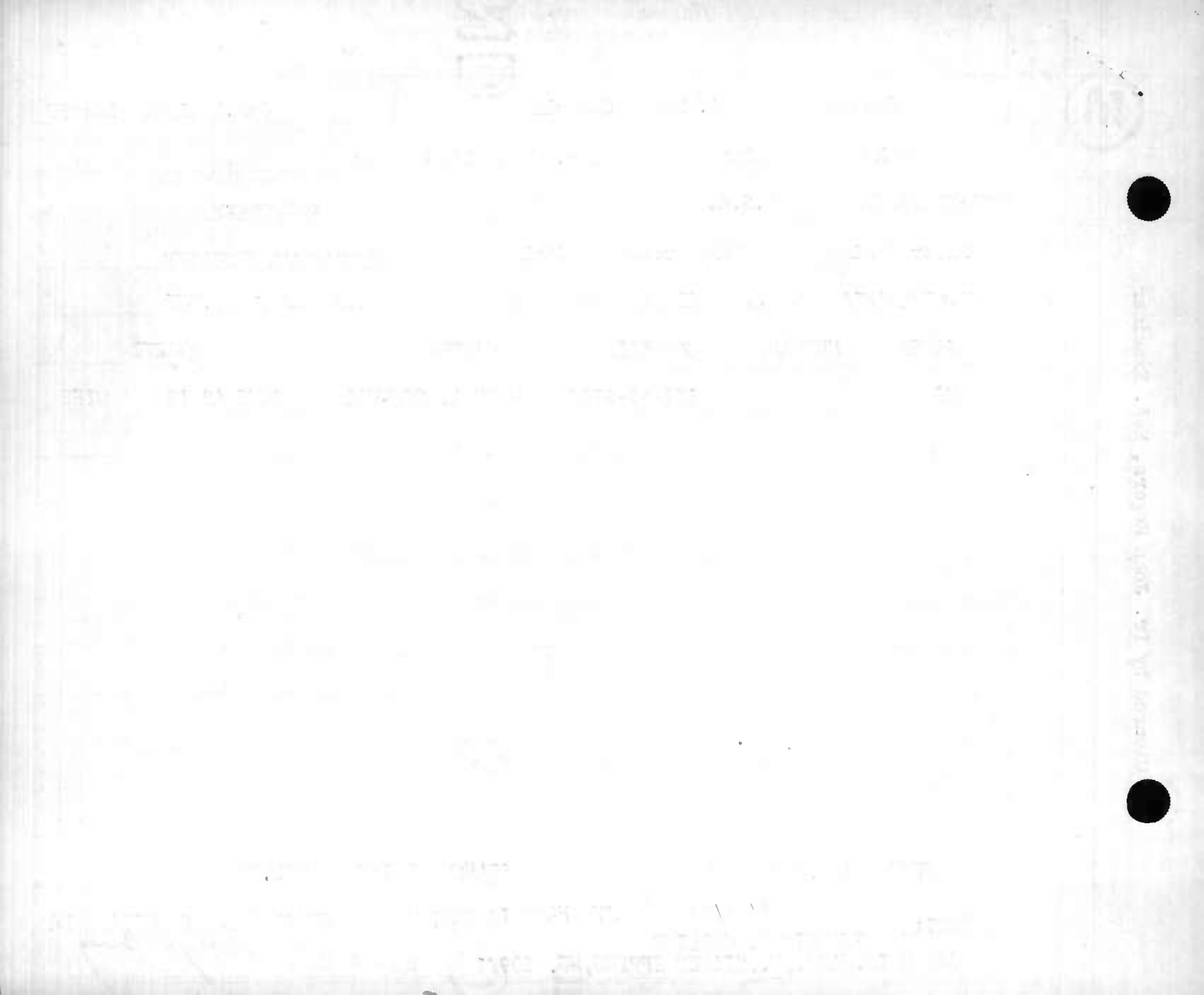
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REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Alton Connell   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 10, 1980 |   | 2b. HOUR<br>12:05 PM  |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 8, 1899  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ELECTRICAL ENGINEER         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE (NAME) COUNTY<br>PENNSYLVANIA CAMBRIA  |  |  |  | 13b. CITY OR TOWN<br>CRESSON  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>416 LAUREL AVENUE                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES HERMAN CONNELL  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARTHA QUARTZ  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>171-05-6706   |  | 17. INFORMANT<br>MARY L. CONNELL  |   | ADDRESS<br>SAME AS 13   |  | WIFE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>5334<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GI Bleeding</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Probably - Peptic Ulcer Disease</u> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>80</u> , to <u>1-10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1-10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Steven A. Burger</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br>1-10-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN A. BURGER   |  |  |  | 22e. ADDRESS<br>SILVER SPRING, MARYLAND   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/14/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. FRANCIS XAVIER  |   | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>CRESSON CAMBRIA PA                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO. 8001950   |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| Helen G. Cook   |  |  |  |   |  |  |  | January 26, 1980  |  | 2:41am  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR MONTHS DAYS  |  | 7 UNDER 24 HRS. HOURS MIN.                                  |  |
| Female  |  | Black  |  | June 11, 1914   |  | 65 YRS   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Wash. D. C.   |  | U.S.A.   |  |   |  | Montgomery MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| Olney   |  | Montgomery General Hospital  |  |   |  |  |  | Housewife   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS   |  |   |  |
| Md.   |  | Montg.   |  | Silver Spring   |  |  |  | 15414 Holly Grove Road  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |   |  |
| Joseph Brogden  |  |  |  | Florence Powell   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |   |  |
| No  |  | 217-32-1571  |  | George Cook (Husband)   |  | same as #13  |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> |  |
| 4151 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE LOBULAR PNEUMONIA</u>  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>PULMONARY INFARCTS, BILATERAL</u>   |  |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic cirrhosis + obliterative Fibrosis Pericarditis.</u>  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
|   |  | P.M. 19  |  |   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN   |  | COUNTY  |  | STATE   |  |
|   |  |  |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>MAY 27</u> 19 <u>80</u> to <u>JAN 26</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>1/26</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the deceased, enter date of death.) |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Donald R. Lewis</u> DEGREE <u>MD</u>  |  |  |  |   |  | 22c. DATE SIGNED <u>1/26/80</u>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DONALD R. LEWIS MD</u>   |  |  |  |   |  | 22e. ADDRESS <u>OLNEY, Md. 20832</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>1-30-80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mutual Memorial Cem.</u>  |  | 23d. LOCATION CITY OR TOWN <u>Sandy Spring</u> COUNTY <u>Montg.</u> STATE <u>Md.</u> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>George R. Snowden</u>  |  | 24b. ADDRESS <u>246 N. Washington Street Rockville, Md. 20850</u>                                      |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 31 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |   |  |   |  |

1-15-71

January 26, 1971

COOK

Major G.

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June 11, 1971

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217-35-1571

no

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO. 8001951  |  |  |  |
|--|--|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD H. COOPERMAN</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>4</b> YEAR <b>80</b>                       |  |  |   |  | 2b. HOUR <b>9:15</b> M  |  |  |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>  |  | 5. DATE OF BIRTH MONTH <b>5</b> DAY <b>23</b> YEAR <b>29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.   |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Kensington</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3707 Astoria Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Decorative Arts</b>  |  |   |  |  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b>   |  |   |  |  | 13c. CITY OR TOWN <b>Kensington</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>3707 Astoria Road</b> |   |  |  |  |
| 14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b></b> LAST <b>Cooperman</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Jennie</b> MIDDLE <b></b> LAST <b>Herskowitz</b> |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean</b>  |  | 17. INFORMANT <b>Ann Cooperman</b>   |  | ADDRESS <b>3707 Astoria Rd, Kensington Md.</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCT</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>ESSENTIAL HYPERTENSION</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ANTERO SEPTAL MYOCARDIAL INFARCT 8/26.</b> |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>&lt; 1 HOUR</b><br><b>3 YEARS</b><br><b>15 YEARS</b> |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NOV 19 64</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET <b>NOV 19 64</b> CITY OR TOWN <b>114</b> COUNTY <b>114</b> STATE <b>80</b>         |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6/19</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>David Goldenberg</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>11/4/80</b>  |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID GOLDENBERG M.D.</b>   |  | 22e. ADDRESS <b>4801 GEORGIA</b>  |  | 22f. ADDRESS <b>SILVER SPRING</b>  |  | 22g. ADDRESS <b>MARYLAND 20902</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-6-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Memorial Park</b>   |  | 23d. LOCATION CITY OR TOWN <b>Falls Church</b> COUNTY <b>Virginia</b> STATE <b></b>                    |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels</b>  |  | ADDRESS <b>1170 Rockville Pike</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John N. ...</b>  |  |   |  |   |  |  |  |



IN SENATE  
JANUARY 12, 1910  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909

ALBANY:  
J.B. LEECH, PRINTERS  
1910



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

0 1 9 5 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |   |  |  |  |  |
|--|--|---|---|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Deets Cordell</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>11</b> YEAR <b>80</b>  |   |  | 2b. HOUR<br><b>10:02am</b>  |  |   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>26,</b> YEAR <b>1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | 8. IF UNDER 74 HRS<br>HOURS <b></b> MIN. <b></b>                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto-Garage</b>   |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Maryland</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>Clarksburg</b>   |  |   |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>23506 Frederick Road</b>  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Eugene</b> MIDDLE <b>-</b> LAST <b>Cordell</b>   |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nettie</b> MIDDLE <b>-</b> LAST <b>Beall</b>               |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-03-2031</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Janet L. Purdum Clarksburg, Md. 20734</b>  |  |   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Idiopathic myocardial infarction</b><br><b>4254</b> DUE TO, OR AS A CONSEQUENCE OF<br>b) <b></b><br>c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b> |  |   |   |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 yrs.</b> |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br>P.M. <b></b> |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>               |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 19 <b>80</b> , to <b>Jan 11</b> , 19 <b>80</b> , that (I) (we) last<br>saw the deceased alive on <b>Jan 10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.   |  |   |   |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick Moomau MD</b>   |  |   |   |   |  | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>1-11-80</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Moomau</b> |  |
| 22e. ADDRESS<br><b>Olney, Md. 20832</b>  |  |   |   |   |  | 22f. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1980</b>   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Jan. 14, 1980</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clarksburg</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Clarksburg</b> COUNTY <b>Mont.</b> STATE <b>Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis H. Barber</b>   |  |   |   |   |  | ADDRESS<br><b>Laytonsville, Md. 20760</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1980</b>                                  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Notary McCready</b>   |  |   |   |   |  |   |  |   |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8001953

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Royston T. (Art) Covington, Jr.</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 29, 1980</b>   |  | 2b. HOUR<br><b>5:00 PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 16, 1920</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chevy Chase Nursing Center</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montg.</b>   |  | 13c. CITY OR TOWN<br><b>Potomac</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Royston T. Covington, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emory Mapp</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 214-10-0295</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Norma G. Covington Same as 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3314 Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Brain Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Hydrocephalus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15' 2 yrs 7 yrs</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>SEPT. 1979</b> to <b>JAN. 29, 1980</b> , that (we) lost<br>saw the deceased alive on <b>JAN 19, 1980</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <b>(I we) (did) (did not)</b> view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Stephen N. Jones</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1-29-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen N. Jones M.D.</b>   |  | 22e. ADDRESS<br><b>809 Viers Mill Road<br/>Rockville, Maryland 20851</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan. 30, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem. Alexandria, Virginia</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Humphrey</b>   |  | ADDRESS<br><b>Homes, P.A. Bethesda, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1980</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pickman</b>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
DATE: [Illegible]  
CLASSIFICATION: [Illegible]  
[Illegible text follows]

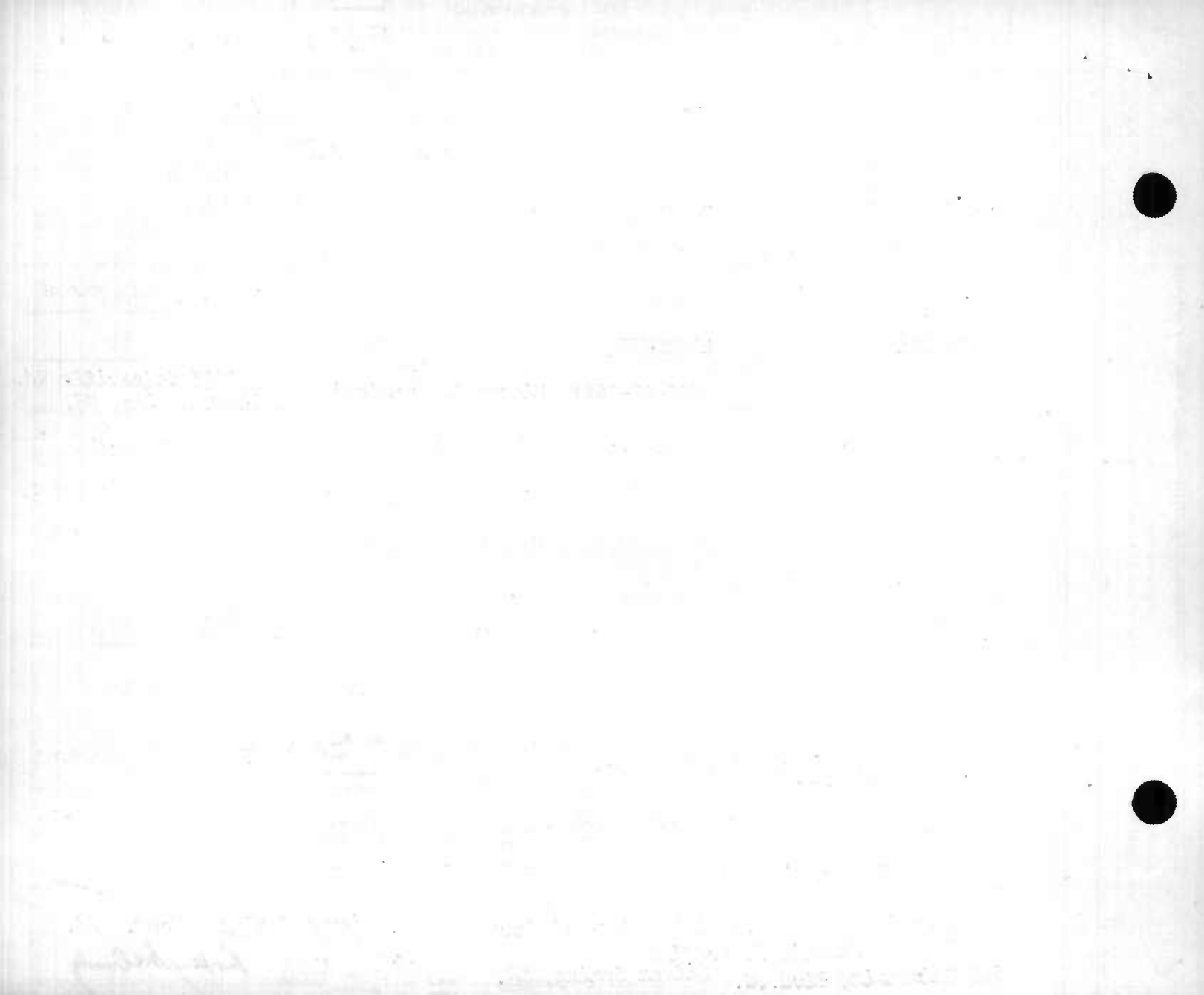
[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 8001954   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Elizabeth LAWRENCE Crawford</i> |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 27 80</i> |  |  | 2b. HOUR<br><i>7:35 A.M.</i>   |  |
| 3 SEX<br><i>FEMALE</i>   |  | 4 RACE<br><i>WHITE</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>9 11 04</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>ENGLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i> MD.                                 |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>SILVER SPRING</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MANOR CARE WHEATON</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE<br><i>MARYLAND MONTGOMERY</i>   |  |   |  | 13c. CITY OR TOWN<br><i>SILVER SPRING</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>2416 DENNIS AVENUE</i>   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>UNKNOWN</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>UNKNOWN</i>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO<br><i>063-07-3588</i>   |  | 17 INFORMANT <i>SON</i> ADDRESS<br><i>Victor L. Crawford 9417 Galesville Rd. Silver Spring, Md.</i>  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i><br><i>4370</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>CEREBRAL ATHEROSCLEROSIS</i><br>(c) <i>GENERAL ARTERIO SCLEROSIS</i> |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>MINUTES</i><br><i>2-3 YEARS</i><br><i>10+ YEARS</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>BRONCHITIS, CHRONIC</i>   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>JAN. 4, 1980</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>GASTRIC CARCINOMA</i>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>OCTOBER 24, 1958</i> to <i>JAN. 27, 1980</i> , that (1) (he) lost saw the deceased alive on <i>JAN. 27, 1980</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (do we) view the body after death.                 |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>James A. Roberts</i>  |  |   |  | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><i>1/27/80</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES A. ROBERTS, M.D.</i>   |  |   |  | 22e. ADDRESS<br><i>8907 GEORGIA AVE. SILVER SPRING, MD.</i>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Jan. 30, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Silver Spring, Mont. Md.</i>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Francis J. Collins</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 1 1980</i>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>History Hebrudy</i>   |  |  |  |
| 500 University Blvd., W. Silver Spring, Md.  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |             |   |                    |  |      |  |   | 8 0 0 1 9 5 5  |                   |  |  |
|--|--|---|-------------|---|--------------------|--|------|--|---|--|-------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.    |   |                    |  |      |  |   |  |                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM   |  |   | FIRST<br>L. |   | MIDDLE<br>CRAWFORD |  | LAST |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/3/80 |  | 2b. HOUR<br>8 P M |  |  |
| 3. SEX<br>m  |  | 4. RACE<br>W  |             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 27 05   |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                       |      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | 7. IF UNDER 24 HRS<br>HOURS MIN.   |                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                           |      |  |   |  |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN |             |   |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Director     |      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dep. of Labor   |   |  |                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |             | 13b. COUNTY<br>Montgomery   |                    | 13c. CITY OR TOWN<br>Gaithersburg  |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |                   | 13e. STREET ADDRESS<br>Apt. T 12<br>437 Christopher Ave. |  |
| 14. FATHER'S NAME<br>FIRST<br>Arthur   |  |   |             | 14. FATHER'S NAME<br>MIDDLE<br>Elliott  |                    | 14. FATHER'S NAME<br>LAST<br>Crawford  |      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Belle   |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br>Ludie  |                   | 15. MOTHER'S MAIDEN NAME<br>LAST                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  |                    | 17. INFORMANT<br>437 Christopher Ave. # T 12<br>Velma Crawford Gaithersburg, Md. |      |  |   |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Ruptured abdominal aneurysm</u><br>4413<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>leaking aortic aneurysm</u><br>(c) <u>gastro-intestinal bleeding</u><br>(d) <u>pulmonary edema</u> |  |   |             |   |                    |  |      |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |             |   |                    |  |      |  |   |  |                   |  |  |
| 19a. DATE OF OPERATION   |  |   |             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                    |  |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                    |  |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                    |  |      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.1.1980 to 1.4.1980, that (I) (we) last saw the deceased alive on 1.3.1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |             |   |                    |  |      |  |   |  |                   |  |  |
| 22b. SIGNATURE<br>Hadi Bahar   |  |   |             | DEGREE  |                    |  |      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>1.4.80   |                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hadi Bahar, M.D.  |  |   |             | 22e. ADDRESS<br>8218 Wisconsin Ave. Beth, Md 20014  |                    |  |      |  |   |  |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |             | 23b. DATE<br>Jan 7, 1980  |                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Blue Ridge Cem.                            |      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Thurmont Frederick Md.   |   |  |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Warner E. Pumphrey   |  |   |             | 4843a. RES. Ga. Ave.<br>Silver Spring, Md.  |                    |  |      | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>Hadi Bahar   |                   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  |   |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | January 31, 1980  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  |
| Male   |  | White  |  | MONTH DAY YEAR<br>01 22 1914  |  | 66 YRS  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)              |  |
| Pa.  |  | USA  |  |   |  | Montgomery MD.  |  | milk processor  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| Bethesda   |  | The Clinical Center, NIH   |  |   |  | fodd industry   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |
| Pennsylvania   |  | Cumberland   |  | Shippensburg  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | Route 6   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| Bruce Simenton   |  | Crouse   |  | Kathryne Jane Magee   |  | No  |  | The Medical Record  |  |
|  |  |  |  |   |  | 198-05-1192   |  | The Clinical Center, NIH, Beth., Md                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |
| PART I. DEATH WAS CAUSED BY:   |  | PART I. DEATH WAS CAUSED BY:   |  | PART I. DEATH WAS CAUSED BY:  |  | PART I. DEATH WAS CAUSED BY:  |  | PART I. DEATH WAS CAUSED BY:  |  |
| IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)   |  | IMMEDIATE CAUSE (a)   |  | IMMEDIATE CAUSE (a)   |  |
| Pneumonia  |  | Pneumonia  |  | Pneumonia   |  | Pneumonia   |  | Pneumonia   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
| Sideroblastic Anemia   |  | Sideroblastic Anemia   |  | Sideroblastic Anemia  |  | Sideroblastic Anemia  |  | Sideroblastic Anemia  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
| Nodular Mixed Lymphoma   |  | Nodular Mixed Lymphoma   |  | Nodular Mixed Lymphoma  |  | Nodular Mixed Lymphoma  |  | Nodular Mixed Lymphoma  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |
| 3 wks.   |  | 3 wks.   |  | 3 wks.  |  | 3 wks.  |  | 3 wks.  |  |
| 1 1/2 yrs.   |  | 1 1/2 yrs.   |  | 1 1/2 yrs.  |  | 1 1/2 yrs.  |  | 1 1/2 yrs.  |  |
| 7 yrs.   |  | 7 yrs.   |  | 7 yrs.  |  | 7 yrs.  |  | 7 yrs.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?            |  |   |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
|  |  |  |  |   |  |   |  |   |  |
| 22a. I certify that (X) this hospital attended the deceased from 16 January, 19 80, to 31 January, 19 80, the XX (we) lost saw the deceased alive on 31 January 19 80, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above X (we) (did) X (we) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |   |  |
| Steven Krasnow M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 2/1/80  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |
| Steven Krasnow, M.D.   |  | The Clinical Center, National Institutes of Health, Bethesda, Md   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |   |  |
| Burial   |  | Feb. 3, 1980   |  | Spring Hill Cemetery  |  | Shippensburg, Cumberland, Penna   |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME  |  | 24b. ADDRESS   |  | 24c. DATE REC'D. BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE  |  |   |  |
| Mervin O. Fogelsanger  |  | 112 W. King St. Shippensburg, Pa.  |  | FEB 8 1980  |  | History ReBundy   |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0001957

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Infant Girl <b>D'Alessandro</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 22 80</b>                           |  | 2b. HOUR<br><b>2:38</b> AM   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 22 80</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Silver Spring</b> Mont. MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert A. D'Alessandro</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marilyn A. Fischer</b>      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Albert A. D'Alessandro, Same as #13</b>                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>non viable fetus</b><br><b>7650</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>23 wk gestation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]                         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 22, 19 80</b> , to <b>JAN 22, 19 80</b> , that (I) (we) lost<br>saw the deceased alive on <b>JAN 22, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Robbie Moyer M.D.</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1/25/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robbie Moyer</b>  |   | 22e. ADDRESS<br><b>19241 Montgomeryville Ave E-23 Gaith Md</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>1/26/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b>  |   | 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Moyer</b>  |  |

1

1. The first thing I noticed when I stepped  
out of the train was the cold. It was a  
sharp, biting cold that I had never  
experienced before. The air was like a  
wall of ice. I pulled my coat tighter  
around me and tried to ignore the  
numbing sensation. The train had just  
arrived from the north, and the  
passengers were all bundled up in heavy  
clothing. I looked around at the  
strangers and felt a little lost.

2. I had heard that the weather was bad,  
but I didn't realize it would be this  
cold. The train conductor told me that  
the temperature was below zero. I  
shivered and tried to keep warm by  
huddling with the other passengers.  
The train stopped at a small station,  
and I saw a few people waiting. They  
were all looking at me with curiosity.  
I felt a little embarrassed. I had  
never been to this part of the country  
before. The conductor told me that I  
was in luck. The weather was supposed  
to get better as I went further south.  
I took a deep breath and stepped out  
of the train. The cold was still there,  
but it didn't feel so bad now. I  
looked up at the sky and saw a few  
stars. It was a beautiful sight. I  
felt a little better. The cold was  
just a small part of the experience.  
I was in a new place, and I was  
about to start a new journey.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8001958   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Carolyn G. Daly  |  |  |  |  |  |  |  | 1-8-80   |  | 5:45 PM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                        |  |
| Female   |  | Caucasian  |  | 10 29 01   |  | 78 YRS.  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Massachusetts  |  | USA  |  |  |  | Montgomery County MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  |  |  |
| Silver Spring  |  | Carriage Hill Nursing Center   |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |
| Housewife  |  | own home   |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Virginia   |  | Fairfax  |  | Alexandria   |  |  |  | 310 Kent Place   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  |
| Alvan C. Gillem  |  | Eily Cummins   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (niece) 441 Fairtree Drive   |  |  |  |  |  |  |  |
|  |  | 578-52-3236-D  |  | Mrs. Mary Daly Severna Park, MD 21146  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Cancer of pancreas  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/79 |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Senile Dementia   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cardiac Arrhythmia, Encephalopathy, Osteoarthritis   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| None   |  | None   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3-19-79, 19____, to 1-8-80, 19____, that (1) (was) lost saw the deceased alive on 1-8-80, 19____, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 22c. DATE SIGNED 1-8-80  |  |  |  |
| George B. Patrick III MD   |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |
| George B. Patrick III MD   |  | 9221 Colesville Rd Silver Spring, Md 20910   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | 1-14-1980  |  | Arlington National   |  | Arlington Virginia   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |
| Warner B. Pumphrey, Inc.   |  | JAN 18 1980  |  | Pumphrey   |  |  |  |  |  |  |  |
| 8434 Ga. Ave., S.S. Md.  |  |  |  |  |  |  |  |  |  |  |  |

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• *Journal of Management Education* 25(1): 10-12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |   | REG. NO. 8001959   |  |  |  |   |  |
|--|--|--|---|---|--|---|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   |  |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Valley Randolph Daniel   |  |  |   |   |  |   |  |  |   | January 18, 1980   |  |  |  | 119 P.M.                                  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White  |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>November 9, 1914   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>65  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  | IF UNDER 24 HRS<br>HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                                    |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Institutes of Health |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |  |  |  |   |  |
| 13a. STATE<br>West Virginia  |  |  | 13b. COUNTY<br>Raleigh Co.  |   |  | 13c. CITY OR TOWN<br>Beckley  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>207 N. Vance Drive    |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John R. Daniel  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Naddie - Davis |   |  |  |   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br>253-10-0484                      |   |  | 17. INFORMANT ADDRESS<br>Mrs. Vivian Daniel Same as # 13                             |   |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of lung</u>                           |  |  |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>minutes<br>weeks  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |   |   |  |   |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |   |  |  |  |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from December 19, 1980 to January 18, 1980, that (x) (we) lost saw the deceased alive on January 18, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) did (do not) view the body after death. |  |  |   |   |  |   |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Michael J. Gallagher   |  |  |   |   |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/18/80                  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael J. Gallagher  |  |  |   |   |  |   |  |  |   | 22e. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Maryland 20205   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |   | 23b. DATE<br>Jan/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Blue Ridge Memorial Gardens   |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Prosperity, West Va.  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Chambers Funeral Home   |  |  |   |   |  |   |  |  |   | ADDRESS<br>Riverdale, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |

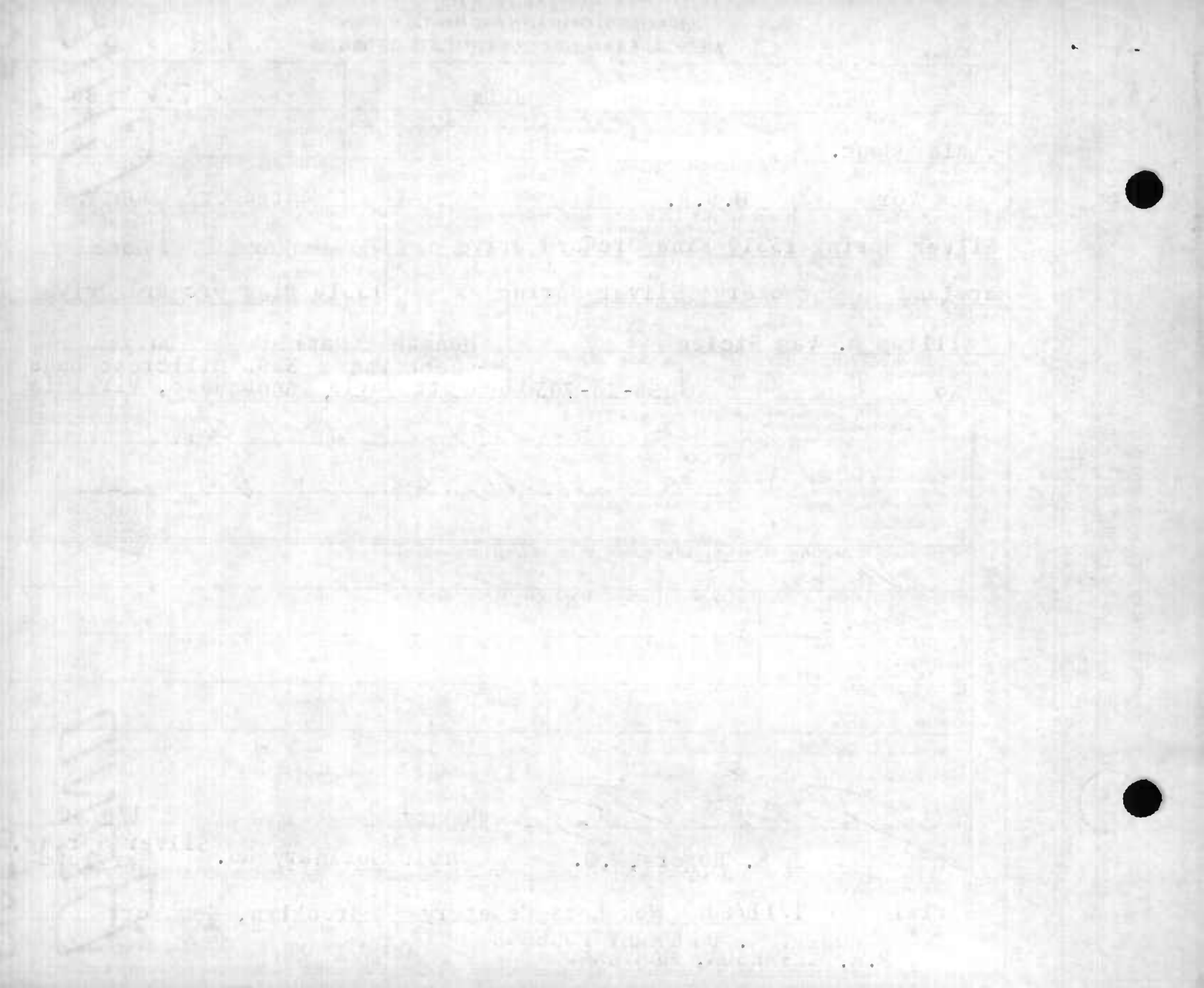
171



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |   |  |   |  |   |  | REC. NO. 01960  |  |   |  |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ida Van Siclen Davis</b>  |  |                         |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>EST. MATED <b>Jan 4 1980</b>   |  | 2b. HOUR<br><b>1:10 PM</b>                                |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11/8/05</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>74 YRS.</b>                             |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br><b>Jan 5 1980</b>   |  | 2d. HOUR<br><b>3:45 PM</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>15310 Pine Orchard Drive</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>  |  |                         |  |   |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>15310 Pine Orchard Drive</b>    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Van Siclen</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hannah Matilda Duryea</b> |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                         |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>058-28-7050</b>                                |  |   |  |   |  | 17. INFORMANT<br><b>Bennett Van Siclen Davis</b>  |  | ADDRESS<br><b>3800 Hillcrest Lane Annandale, Virginia</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>1/6/80</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers, M.D.</b>  |  |                         |  | ADDRESS<br><b>1919 Seminary Rd. Silver Spring, Maryland</b>   |  |   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>1/11/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Lots Cemetery</b>                |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn, New York</b> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. BUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1980</b>                           |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pietro McCreedy</b>                    |  |   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

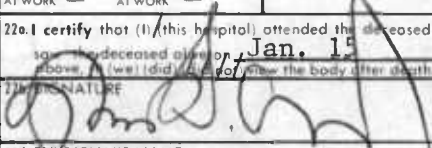



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>THOMAS Cahill DAVIS, Jr.   |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>January 15 1980         |  | 2b HOUR<br>6:10A M                                |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>March 9 1937   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Navy   |   | 12b KIND OF BUSINESS OR INDUSTRY<br>US Gov't  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Virginia  |  |  |  |  | 13b CITY OR TOWN<br>Arlington                              |  | 13c STREET ADDRESS<br>107 North Greenbriar Street |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Cahill Davis, Sr.  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Angela Murray |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>1962-80   |  | 17 INFORMANT<br>Mrs. Marilyn Davis   |  | ADDRESS<br>See item 13   |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary consolidation and hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse Hodgkins disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse pneumonia</u> |  |  |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |   |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 6</u> , 19 <u>80</u> , to <u>Jan. 15</u> , 19 <u>80</u> , that (I) (we) lost above <u>Jan. 15</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated                       |  |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>Jan. 15, 1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John F. Eisold, M.D.   |  |  |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 18, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va.  |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br>W. W. Chambers Co.  |  |  |  | ADDRESS<br>Silver Spring, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>Jan 25 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>                   |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0001962

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARCIANA<br/>Marclena</b>  |  |  | 2a. DATE OF DEATH<br>January 16, 1980  |  |  | 2b. HOUR<br>3:10P.  |  |  |
| 3. SEX<br>female  |  |  | 4. RACE<br>white   |  |  | 5. DATE OF BIRTH<br>June 21, 1923   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife   |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Howard  |  |  | 13c. CITY OR TOWN<br>Lisbon   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Gray   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Thompson  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 20 6244   |  |  | 17. INFORMANT<br>Rt# 144<br>Clyde M. Deavers Lisbon, Maryland 21765   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr. - unknown |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>1/14/80   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Stall stones   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <u>Jan 16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Arthur F. Woodward</u>   |  |  | DEGREE   |  |  | 22c. DATE SIGNED<br>1/16/80   |  | 22d. ADDRESS<br>115 N. Van Buren St.<br>Rockville, Md. 20850   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR F. WOODWARD   |  |  | 22f. ADDRESS   |  |  | 22g. DATE REC'D. BY REGISTRAR   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |  | 23b. DATE<br>1/21/80   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Mem. Garden, Marriottsville, Howard, Md.   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SLACK Funeral Home, Ellicott City, Maryland 21043   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>   |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Faint text at the bottom of the page, possibly a footer or page number.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

Released by Dr. Ball, deputy medical examiner

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8001963  |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ralph De Carlo   |  |   |  | 1.15.80   |  |   |  | 11:46 AM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 12, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Gardener Larchmont             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursery   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Rockville  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>1624 Tweed Street   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Donald DeCarlo  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Not Available  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>086 09 6104   |  | 17. INFORMANT ADDRESS<br>Donald DeCarlo same as item 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22. I certify that <u>Suburban Hospital</u> attended the deceased from <u>December 19, 1977</u> to <u>Jan-15, 1980</u> , that <u>he</u> (we) last saw the deceased alive on <u>Jan-15, 1980</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>if</u> (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Sidney J. Cohen, M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>1/16/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sidney J. Cohen, M.D.   |  |   |  | 22e. ADDRESS<br>121 Congressional Lane, Rockville, Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/19/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Sepulchre  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>New Rochelle, New York                               |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCandless</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

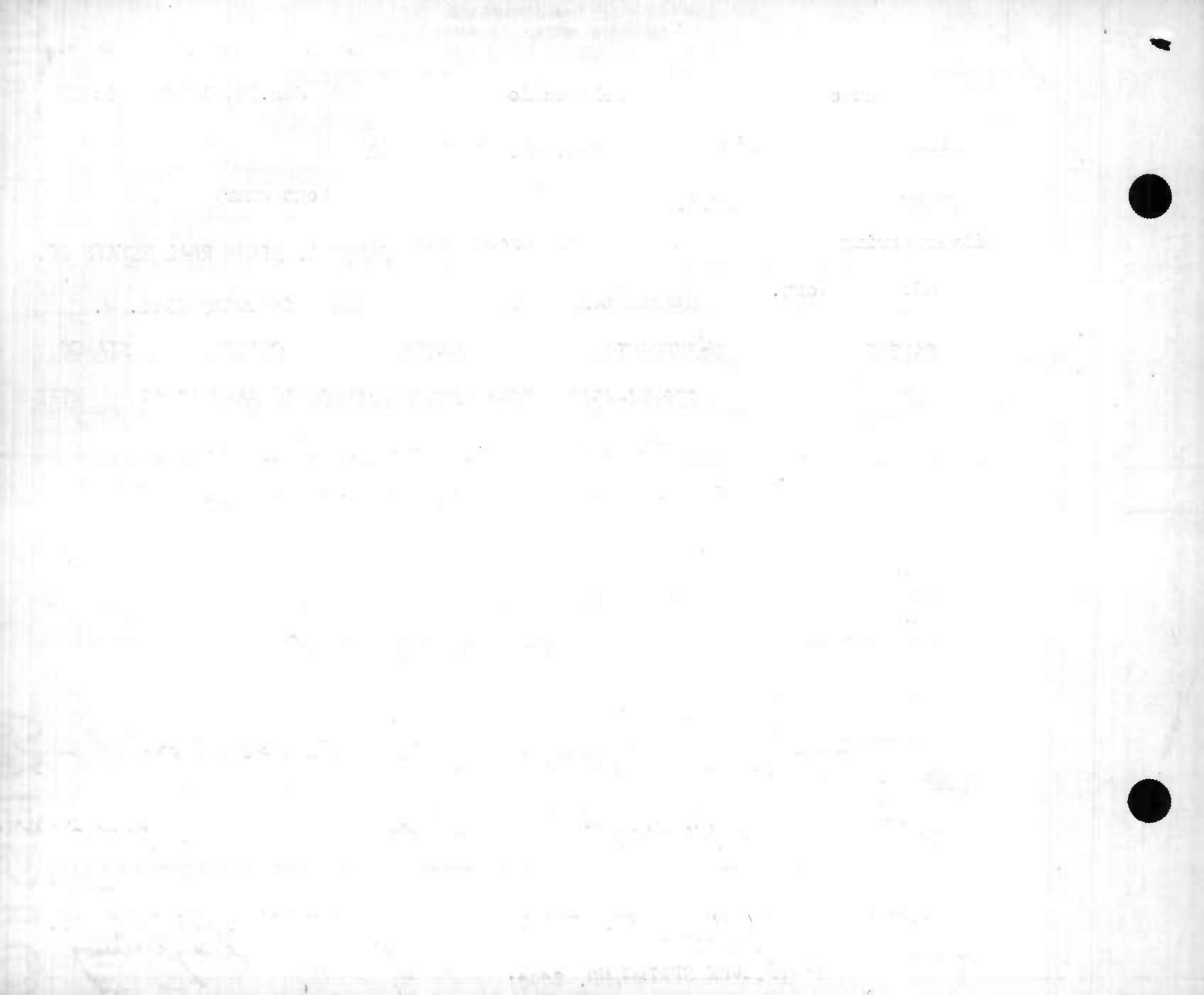
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3601

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |  |   | 8 0 0 1 9 6 4<br>REG. NO.                                     |   |  |  |
|---|--|---|--|--|---|---|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony DelVecchio</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 22, 1980</b>                                     |   |  |  | 2b. HOUR<br><b>2:22P</b>                        |   | M |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 28, 1898</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |   | IF UNDER 24 HRS<br>HOURS MIN                                  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |   |   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>JAMES L. DIXON REAL ESTATE CO.</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MD.</b> |   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13b. STREET ADDRESS<br><b>3333 University Blvd. W.</b> |  |   |   |   |  |  |
| 13a. STATE<br><b>md.</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Kensington</b>   |   |   |  |  |   |   |   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAVINO DelVECCHIO</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIA GRAZIA STANGO</b>                     |   |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579-34-4560</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>DONA ASHLEY DELVECCHIO SAME AS 13 WIFE</b>   |   |   |  |  |   |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b>                    |  |   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Vrs</b> |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>   |  |   |  |  |   |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |   |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Sept. 19 82</b> to <b>Jan 22, 19 80</b> , that (I) (we) last saw the deceased alive on <b>1-21</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>John S. Rogers</b>   |  |   |  |  | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-22-80</b>                            |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN S. ROGERS</b>  |  |   |  |  | 22e. ADDRESS<br><b>1919 SEMINARY ROAD, SILVER SPRING, MARYLAND</b>                              |   |  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BRENTWOOD PRI GEO MD.</b>                                |  |  |   |   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>FRANCIS J. COLLINS<br/>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCrady</b>   |   |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8001965   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                              |  | 2b. HOUR                                     |  |
| May   |  | W.   |  | DeMartine   |  |   |  | 1 22 1980   |  | 8:30p <sub>M</sub>                           |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7 UNDER 1 YEAR MONTHS DAYS                                    |  | 7 UNDER 24 HRS HOURS MIN                     |  |
| Female  |  | White  |  | 6 15 1888   |  | 91 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| N.Y.  |  | U.S.A.   |  |   |  | Montgomery MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Rockville   |  | Rockville Nursing Home   |  |   |  |   |  | Glovemaker  |  | Garment                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS   |  |  |  |
| Md.   |  | Montgomery   |  | Potomac   |  |   |  | 8502 Post oak Road  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |   |  |  |  |
| Eugene  |  | Hubbell  |  | Emma  |  | Ortell  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |   |  |   |  |  |  |
| No  |  | 076-03-1114A   |  | Jean Dembo same as 13e  |  |   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic brain syndrome</u>   |  |  |  |   |  |   |  |   |  | 48 hr.                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized atherosclerosis</u>   |  |  |  |   |  |   |  |   |  | years  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic degenerative joint disease</u>   |  |  |  |   |  |   |  |   |  | years  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 1975 to JAN 22, 1980, that (I) (we) lost saw the deceased alive on 1/22/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Faruk Togo Ozer</u>   |  | DEGREE MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED 1/23/80  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |   |  |  |  |
| Faruk Togo Ozer, M.D.   |  | 11125 Rockville Pike Rockville, Md.  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| Burial  |  | 1/26/80  |  | Prospect Hill Cemetery  |  | Gloversville Fulton   |  | N.Y.  |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |  |  |
| Tyson Wheeler Funeral Home, Inc.  |  | JAN 28 1980  |  | T. K. K. K. K.  |  |   |  |   |  |  |  |
| 1331 Rockville Pike Rockville, Maryland 20852   |  |  |  |   |  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |   |  |  |  |  |   |  |
|--|--|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thelma B. De Vore</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>04</b> YEAR <b>80</b>   |  |   | 2b. HOUR<br><b>1:30AM</b>  |  |  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>Oct.</b> DAY <b>31</b> YEAR <b>1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery Gen. Hospital</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |  |   |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Sil. Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Ernest</b> MIDDLE <b></b> LAST <b>Bloomgren</b>  |  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Selma</b> MIDDLE <b></b> LAST <b>Nelson</b>     |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>  |   | 17. INFORMANT (husband)<br><b>Elmer J. DeVore-(same as 13e)</b>  |   | ADDRESS<br><b>2201 Drury Lane,</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 minutes</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>OCVA; Diabetes Mellitus</b>   |  |  |   |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br>P.M. <b></b> |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |   | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>    |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/2</b> , 19 <b>80</b> , to <b>1/4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael A. Bolognese</b>  |  |  |   |  |   | DEGREE<br><b></b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/4/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael A. Bolognese</b>   |  |  |   |  |   | 22e. ADDRESS<br><b>19261 Mont. Village Ave G-23 Gaithersburg, Md. 20860</b>          |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Jan. 8-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakland Cemetery</b> |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Warren</b> COUNTY <b></b> STATE <b>Penna.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b><br><b>8434 Ga. Ave., S.S. Md.</b>  |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1980</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert J. Brandy</b>  |  |   |  |

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Antiquary

Department of the Interior

Chief

*John Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8001967

1. FOR  
STATE  
REGISTRAR

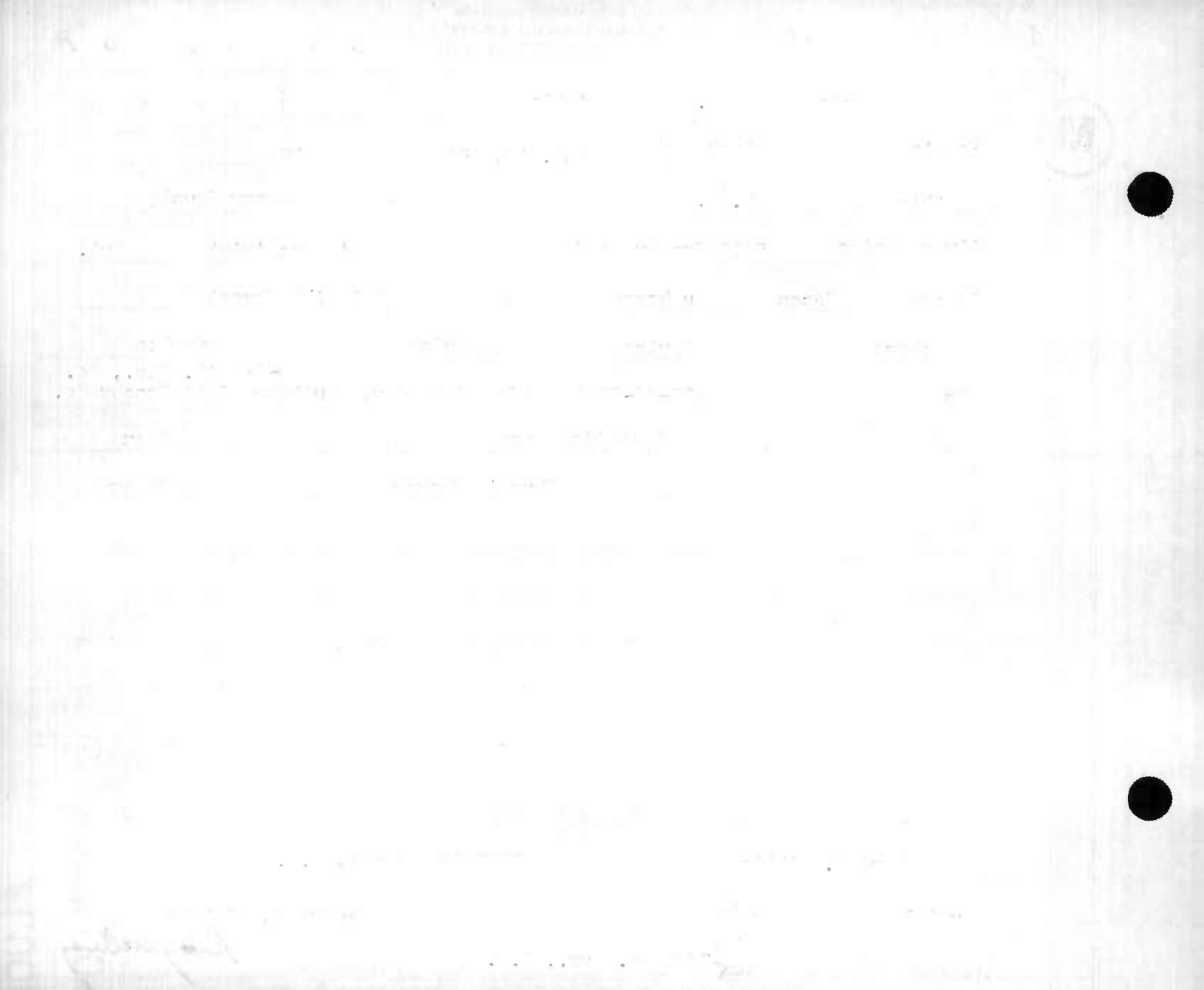
|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Helen T. Dibble   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN. 6, 1980                                 |  | 2b. HOUR<br>10:45 AM                      |
| 3. SEX<br>Female  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 15, 1900   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                              |   |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9101 Crosby Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ass't Archivist |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pvt. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Alabama |   |   | 13b. COUNTY<br>Macon  | 13c. CITY OR TOWN<br>Tuskegee  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Taylor   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beatrice Rochon                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>423-64-5311   |   | 17. INFORMANT<br>ADDRESS<br>c/o Sil. Spr., Md.<br>Helen Cannaday, Daughter 9101 Crosby Rd. |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Metastatic Cancer |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 yrs |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) Thyroid Cancer   | 21 yrs   |
|  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |
|  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): |  |

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from July 5, 1979, to Jan. 6, 1980, that (I) (we) last saw the deceased alive on 1-6-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br>Robert Taylor Dibble MD  |  |  |  | 22c. DATE SIGNED<br>1-6-80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert T. Dibble  |  |  |  | 22e. ADDRESS<br>5505 5th Street, N.W.                                     |   |

|   |                     |   |   |
|---|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial    | 23b. DATE<br>1/8/80 | 23c. NAME OF CEMETERY OR CREMATORY          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Tuskegee, Alabama |
| 24. FUNERAL DIRECTOR<br>NAME<br>M. G. Givens Funeral Soc. |                     | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1980 |   |
| 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H.                 |                     |   |   |

BP



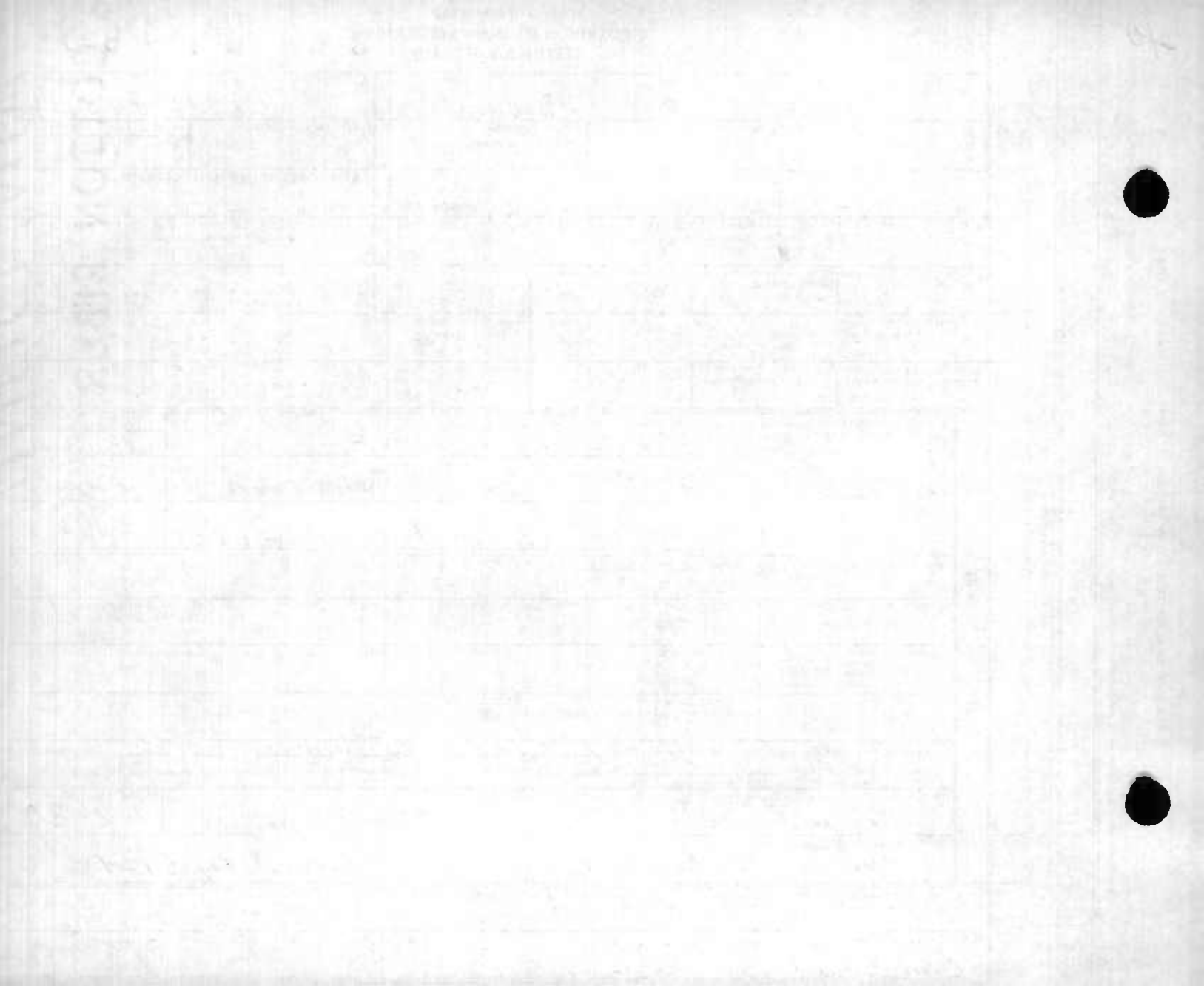


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 0001968  |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ESTELLE T. DIEHL</b>  |  |   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-10-80</b>                                |  | 2b. HOUR<br><b>3:05 AM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 29 96</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD</b>                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carroll Manor</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>saleslady</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |  |  |  |  |
| 13a. STATE<br><b>Va.</b>   |  | 13b. CITY OR TOWN<br><b>Fairfax</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>1658 Quail Hollow Ct.</b>                                  |  |  |  |
| 14. FATHER'S NAME<br><b>Edward H. Tompkins</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Louise O. Chapelle</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-26-3888</b>  |  | 17. INFORMANT<br>ADDRESS <b>McLean Va.</b><br><b>Chas.E. Diehl 1658 Quail Hollow Ct.</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>VIRAL PNEUMONIA</b><br><b>4409</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC BRAIN SYNDROME</b><br>(c) <b>GENERALIZED ARTERIOSCLEROSIS</b>                 |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 days</b><br><b>5 years</b><br><b>5 years</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> , 19 <b>75</b> , to <b>JAN 10</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>JAN 8</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Thomas F. Collins MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   |  |  | 22c. DATE SIGNED<br><b>1-16-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS F. COLLINS MD</b>   |  |   |  | 22e. ADDRESS<br><b>2600 Queen Chapel Rd</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/14/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l Mem. Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Fx. Va.</b>           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Murphy FH</b><br><b>C.M. Francis</b>  |  |   |  | 4540 Wilson Blvd.<br><b>Arlington, Va.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1980</b>                                  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |  |  |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REC. NO. 01969  |  |                                    |  |
|---|--|---|--|---|--|---|--|--|--|---|--|------------------------------------|--|
| 1- FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>Martin E. Dietz</b>   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 1-12 1980 |  | 2b. HOUR<br>A M<br><b>A</b>   |  |                                    |  |
| 3 SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 12, 1896</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>83</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Jan - 12 1980</b>                  |  | 2d. HOUR<br>A M<br><b>11:15 AM</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Auburn, New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5018 Rodman Road</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Public Relations</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Treasury Dept</b>                           |  |                                    |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5018 Rodman Road</b>   |  |   |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin Dietz</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gaynor</b>   |  |   |  | 16. ADDRESS<br><b>Amissville, Va.</b>  |  |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>088-01-7220</b>  |  | 17. INFORMANT<br><b>Deborah Dietz, Dtr/ Box 74M Rtl.</b>  |  |  |  |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |   |  |  |  |   |  |                                    |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                    |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |  |  |   |  |                                    |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |  |   |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  | DATE<br><b>Jan 12-1980</b>   |  |   |  |                                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball</b>   |  |   |  | ADDRESS<br><b>7936 Old Georgetown Rd., Beth., Md.</b>   |  |   |  |  |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/14/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Md.</b>                         |  |   |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons Inc.</b>  |  |   |  | ADDRESS<br><b>5130 Wisc Ave., Wash</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. Ball</b>                                 |  |                                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other funeral arrangements.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |                   | REG. NO. 8001970   |  |
|---|--|--|--|---|--|--|--|---|-------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH NMN DiGiorgio   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 4, 1980                                  |  |   | 2b. HOUR<br>6 A M |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 24, 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |                   | 8. IF UNDER 72 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY County, MD                        |  |   |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U. S. Gov't  |                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>GAITHERSBURG  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   | 13e. STREET ADDRESS<br>19153 ROMAN WAY   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Alfio DiGiorgio  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Muscolino   |  |  |  |   |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW 11  |  | 17. INFORMANT<br>Eileen M. DiGiorgio, Same as 13  |  | ADDRESS  |  |   |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>335-2<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> |  |  |  |   |  |  |  |   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE<br>5 DAYS<br>2 YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>ILEUS</u>   |  |  |  |   |  |  |  |   |                   |  |  |
| 19a. DATE OF OPERATION<br>NONE  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NONE   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |   |                   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/3 1980, to 1/4 1980, that (I) (the) last saw the deceased alive on 1/3 1980, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.     |  |  |  |   |  |  |  |   |                   |  |  |
| 22b. SIGNATURE<br>Alan N. Schulman  |  |  |  | DEGREE<br>M.D.  |  |  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                   | 22c. DATE SIGNED<br>1/4/1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN N. SCHULMAN, M.D.   |  |  |  | 22e. ADDRESS<br>19271 MONTGOMERY VILLAGE AVENUE<br>GAITHERSBURG, MD. 20760  |  |  |  |   |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>1-7-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Alexandria, Virginia             |  |   |                   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |                   |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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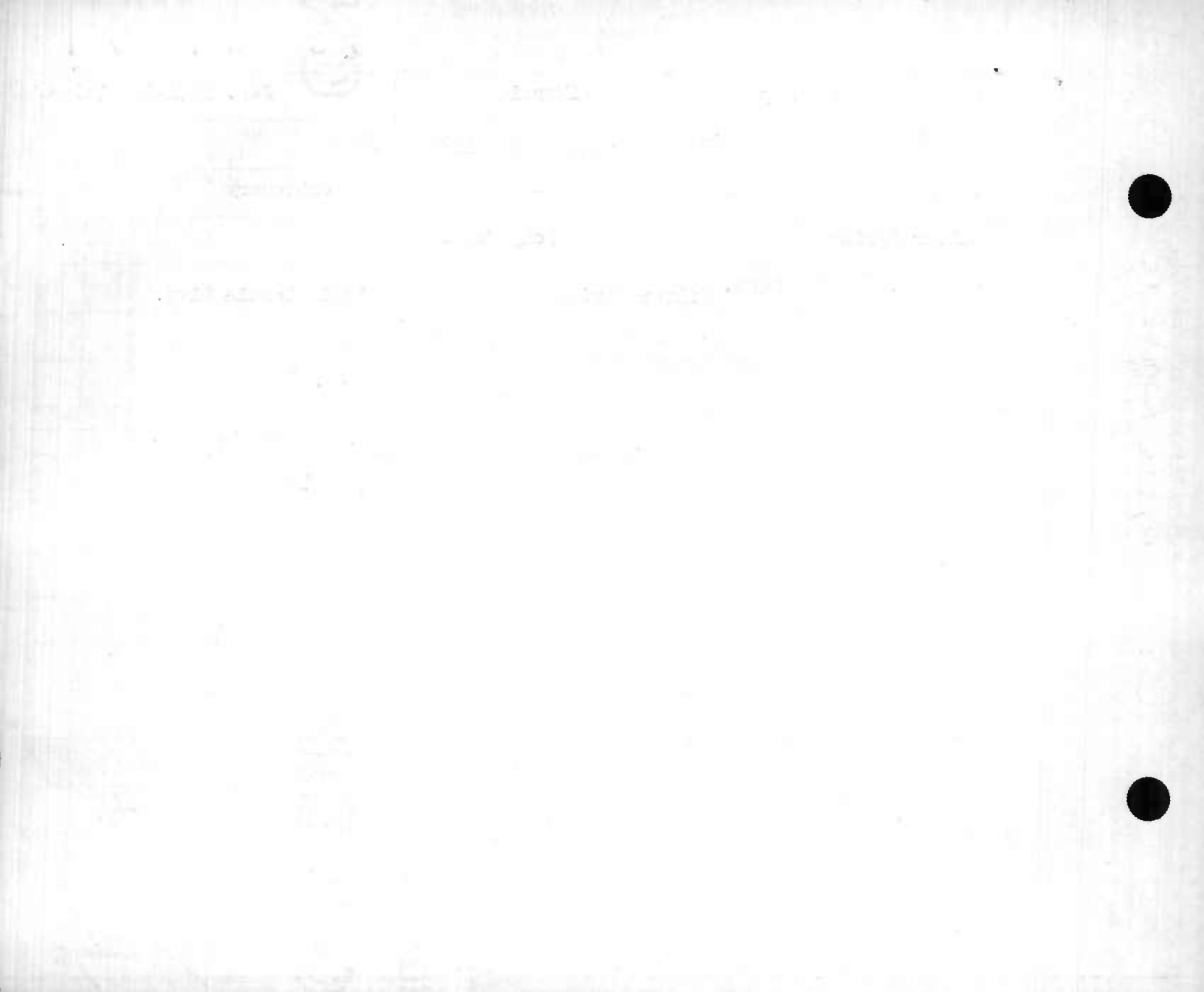
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 8001971   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Federico DiMarzio   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 15, 1980   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>7:19A M                             |  |  |  |  |                               |  |  |  |  |
| 3 SEX<br>Male   |  |  |  |  | 4 RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 17, 1926  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  |  |  |  | IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Resident   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross |  |  |  |  |   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-Employed   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant |  |  |  |  |                               |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Silver Spring   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 13e. STREET ADDRESS<br>13920 Castle Blvd.  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Florindo DiMarzio  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maria Ponnito   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>None   |  |  |  |  | 16b. SOCIAL SECURITY NO<br>084 36 9381   |  |  |  |  | 17. INFORMANT Same as above ADDRESS<br>Giuseppina DiMarzio (Wife)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC, VENTRICULAR TACHYARRHYTHMIA</u><br>396-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RHEUMATIC HEART DISEASE - PROSTETIC</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AORTIC AND MITRAL VALVE</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976 to 1980, that (I) (we) lost saw the deceased alive on JAN. 4 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>Joseph M. Solinas<br>DEGREE MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>1/15/80                     |  |  |  |  |                               |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Solinas   |  |  |  |  | 22e. ADDRESS<br>9801 Ga. Ave. S.S. Md.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  |  | 23b. DATE<br>1/19/80   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>S.S. Mont. Md.  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>H/R Funeral Home 11800 N.H. Ave. S.S. Md.  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>History McCreedy  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                         |  |   |  |   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |   |  |  |  | REG. NO. 01972            |  |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWIN A. DINSMORE</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> <b>1-22 1980</b>                          |  |   |  |   |  |   |  |  |  | 2b. HOUR <b>9:40 P.M.</b> |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Apr 11 1929</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS. <b>50</b> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br><b>1-22 1980</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |  |   |  |  |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b>                        |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>   |  |   |  |  |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Hospital</b> |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| 13a. STATE<br><b>Md.</b>   |  |                         |  |   |  |   |  |   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Galthersburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>19331 Frenchton Place</b> |  |  |  |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin Dinsmore</b>  |  |                         |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes McCarthy</b>                                  |  |   |  |   |  |   |  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes Korean</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>178-24-7085</b>  |  |   |  | 17. INFORMANT<br><b>Evans F.H.</b>  |  |   |  | ADDRESS<br><b>St. Clair, Penna. 17970</b>   |  |   |  |   |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>1-23-80</b>   |  |   |  |   |  |  |  |                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>1-26-80</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Queen of Universe</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pottsville Penna.</b>              |  |   |  |   |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons</b>   |  |                         |  | ADDRESS<br><b>4905 York Rd. Balto. Md. 21212</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry W. Jenkins</i>                               |  |   |  |   |  |  |  |                           |  |

• **התאמה:** התאמה בין המצב הנוכחי לבין המצב הרצוי.

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STEFAN, 6th ed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 9 7 3  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |  |   |   |  |
|---|--|---|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAE DLUH Y</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Jan. 28 '80</b>  |  |  | 2b. HOUR<br><b>11:15 AM</b>  |  |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 26 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN Hospital</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>D.C.</b> 13b. CITY OR TOWN <b>Washington</b>  |  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13d. STREET ADDRESS<br><b>3709 KEGONAS St, N.W.</b>  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rudolph Liska</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine unlk</b>                          |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Dr. John Dlutiy, see (13a)</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>4414<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>abdominal aortic aneurysm</b><br>(c) <b>arteriosclerosis</b>    |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Carcinoma Breast</b>  |  |   |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/21/80</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca. of Breast</b>                        |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                               |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1978</b> , to <b>1/28/80</b> , that (I) (we) last saw the deceased alive on <b>1/28/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Thos G. Ward</b> DEGREE  |  |   |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/28/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward</b>  |  |   |   |  |  | 22e. ADDRESS<br><b>6116 Relinwood, Bethesda, Md 20814</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE IF)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>FEB. 1, 1980</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Queen-Heaven</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hillside COOK IL</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.W. Chambers, Silver Spring, Md</b>   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruth K. J.</b>   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | 8 0 0 1 9 7 4<br>REG. NO.  |  |  |  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>James V Domenico</b>  |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 14 80</b>   |  |  |  | 2b HOUR<br><b>0736 A</b>  |  |
| 3 SEX<br><b>M</b>   |  | 4 RACE<br><b>W</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 23 30</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adv.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>             |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>I.B.M.</b>   |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>MONTGOMERY</b>  |  | 13c CITY OR TOWN<br><b>GAITHERSBURG</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>768 TIFFANY DRIVE</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES DOMENICO</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LEONA CICHOWSKI</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | (IF YES, GIVE WAR OR DATES)<br><b>KOREA</b>  |  | 16b SOCIAL SECURITY NO<br><b>125-20-0293</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>ELEANOR B. DOMENICO (SAME AS 13e)</b>                            |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min.</b><br><b>10 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:00 P.M. 7/14 1980</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>768 Tiffany Drive Rockville Montgomery MD.</b>  |  |  |  |   |  |
| 22a I certify that (I) (the undersigned) attended the deceased from <b>7/14/80</b> to <b>7/14/80</b> , that (I) (we) last saw the deceased alive on <b>7/14/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>Robert C. Macon</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  |  |  | 22c DATE SIGNED<br><b>7/14/80</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT C. MACON</b>  |  |  |  | 22e ADDRESS<br><b>809 VIERS MILL RD., ROCKVILLE, MD.</b>   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b DATE<br><b>1-17-80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN CEM.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONTG. MD.</b>                   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT A. PUMPHREY FUNERAL HOMES P/A ROCKVILLE MD.</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Robert C. Macon</b>  |  |   |  |

10/10/80 - 10/10/80 - 10/10/80





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George T. Donahue   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 21, 1980   |  | 2b. HOUR<br>6:34P M   |  |
| 3 SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 22, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.J.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Consultant                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Potomac  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>12017 Edge Park Court  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert F. Donahue  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Egar  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW II 119-32-6788   |  | 17. INFORMANT ADDRESS<br>Mary R. Donahue- Same as Item # 13   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u><br>4140 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) <u>Coronary atherosclerosis</u><br>gave rise to immediate }<br>cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF<br>underlying cause last } (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>minutes</u> |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12 Jan 77</u> to <u>21 Jan 80</u> , that (I) (we) last saw the deceased alive on <u>Jan 14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed and sealed the body after death.   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Jere J. Daum</u>   |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jere J. Daum, M.D.   |  | 22d. ADDRESS<br>7505 Democracy Blvd<br>Bethesda, Md. 20034  |  | 22e. DATE SIGNED<br>22 Jan 80   |  | 22f. SIGNATURE<br><u>History McCreedy</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/24/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Gabriel's Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Potomac, Md.                                      |  | 23e. DATE REC'D. BY REGISTRAR<br>JAN 28 1980  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler, Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>History McCreedy</u>   |  |   |  |





## MEDICAL CERTIFICATION

DHMH-16 25M  
(VRA 15, 4) 1/79

5000 BP

430

Witchamper Ave. 12

1000 Chase Ave.

Witchamper

Witchamper

Witchamper

Witchamper

Witchamper

Witchamper

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8001977

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas E. Dunn                      |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 14, 1980                   |   |  | 2b. HOUR<br>9:30 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8, 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                 |  |
| 10. CITY OR TOWN OF DEATH<br>Kensington                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kensington Gardens |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman |  |
|  |  |   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Goods Sporting                          |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Chevy Chase                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas E. Dunn                   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jennie Woodward       |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>090-07-9128 |   | 17. INFORMANT<br>ADDRESS<br>Patricia D. Davis, Same as #13 |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4409

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Congestive heart failure

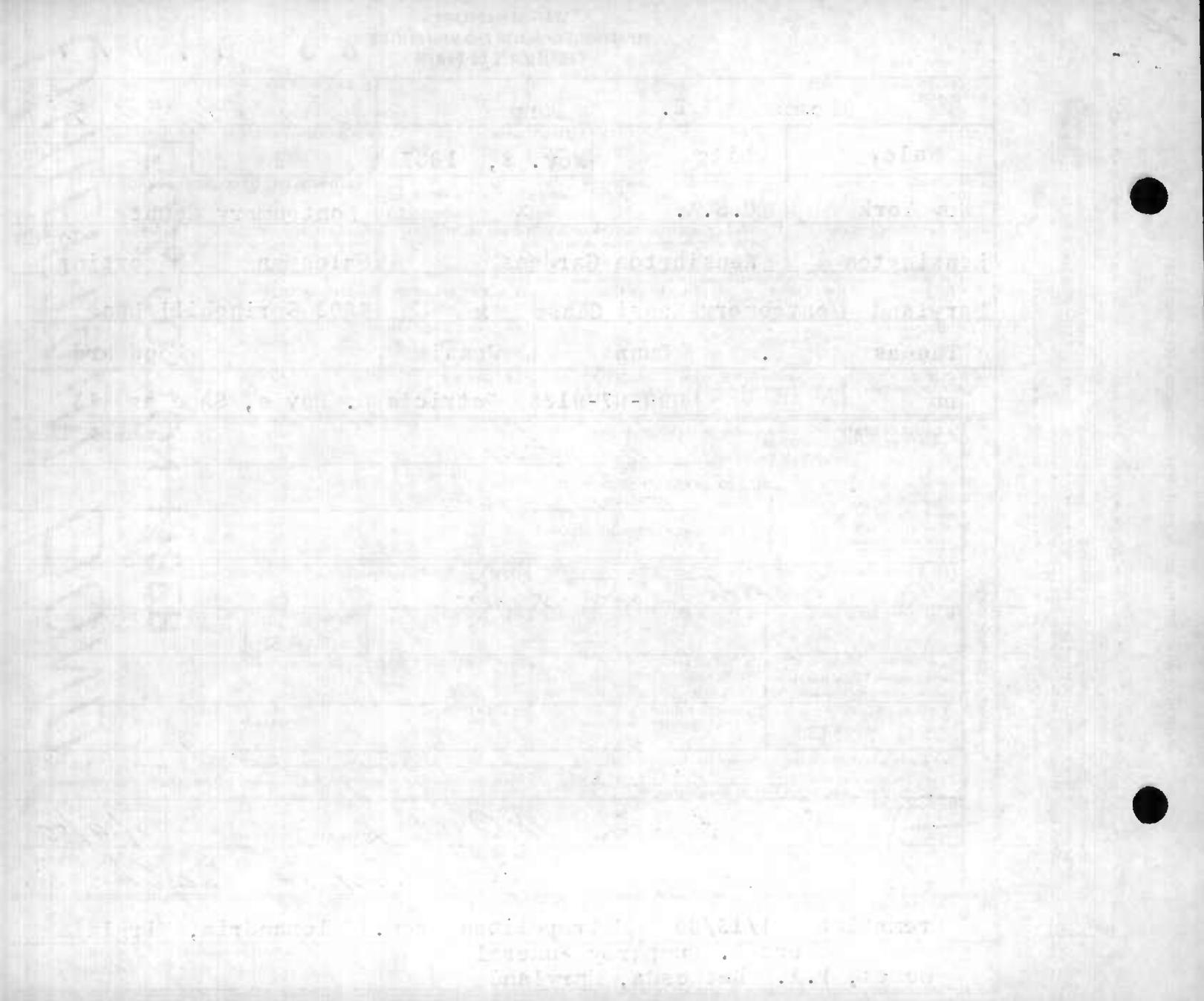
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 67 to 19 80, that (I) (we) last saw the deceased alive on 1/13/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>John B. Umken MD  |  |  |  | 22c. DATE SIGNED<br>1/14/80  |  | 22d. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John B. Umken  |  |  |  | 22f. ADDRESS<br>8805 Conn. Ave. Chevy Chase, Md.                                     |  |  |  |

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>1/15/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Robert A. Humphrey Funeral<br>Homes, P.A. Bethesda, Maryland |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980             |  | 25b. REGISTRAR'S SIGNATURE<br>Marilyn McCreedy                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 1 9 7 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |                        |   |  |   |                          |
|---|------------------------|---|--|---|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES JOSEPH DONEGAN</b>  |                        |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 13, 1980</b> |   | 2b. HOUR<br><b>9:53p</b> |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 8, 1916</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS   |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                             |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AERONAUTICAL ENG</b>     |                          |
| 13a. STATE<br><b>MARYLAND</b>   |                        | 13b. COUNTY<br><b>MONTGOMERY</b>  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES J. DONEGAN, SR.</b>   |                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN KOHNS</b>  |  |   |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |                        | 16b. SOCIAL SECURITY NO.<br><b>149-07-9328</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>DOROTHY T. DONEGAN SAME AS 13 WIFE</b>                            |                          |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Aortic Stenosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |                        |   |  |   |                          |
| 19a. DATE OF OPERATION  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>80</b> , to <b>1/13</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>1/13</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |                        |   |  |   |                          |
| 22b. SIGNATURE<br><b>Alberto Rotstein</b>   |                        | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/13/80</b>  |                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERTO ROTSTEIN</b>  |                        | 22e. ADDRESS<br><b>10401 Old Georgetown Rd. Bethesda, Md. 20014</b>   |  |   |                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |                        | 23b. DATE<br><b>1/17/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>                                     |                          |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT. MD.</b>  |                        | 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1980</b>   |                          |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>   |                        | 25c. REGISTRAR'S NAME<br><b>Robert McBrady</b>  |  |   |                          |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[illegible]

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250-70-561



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

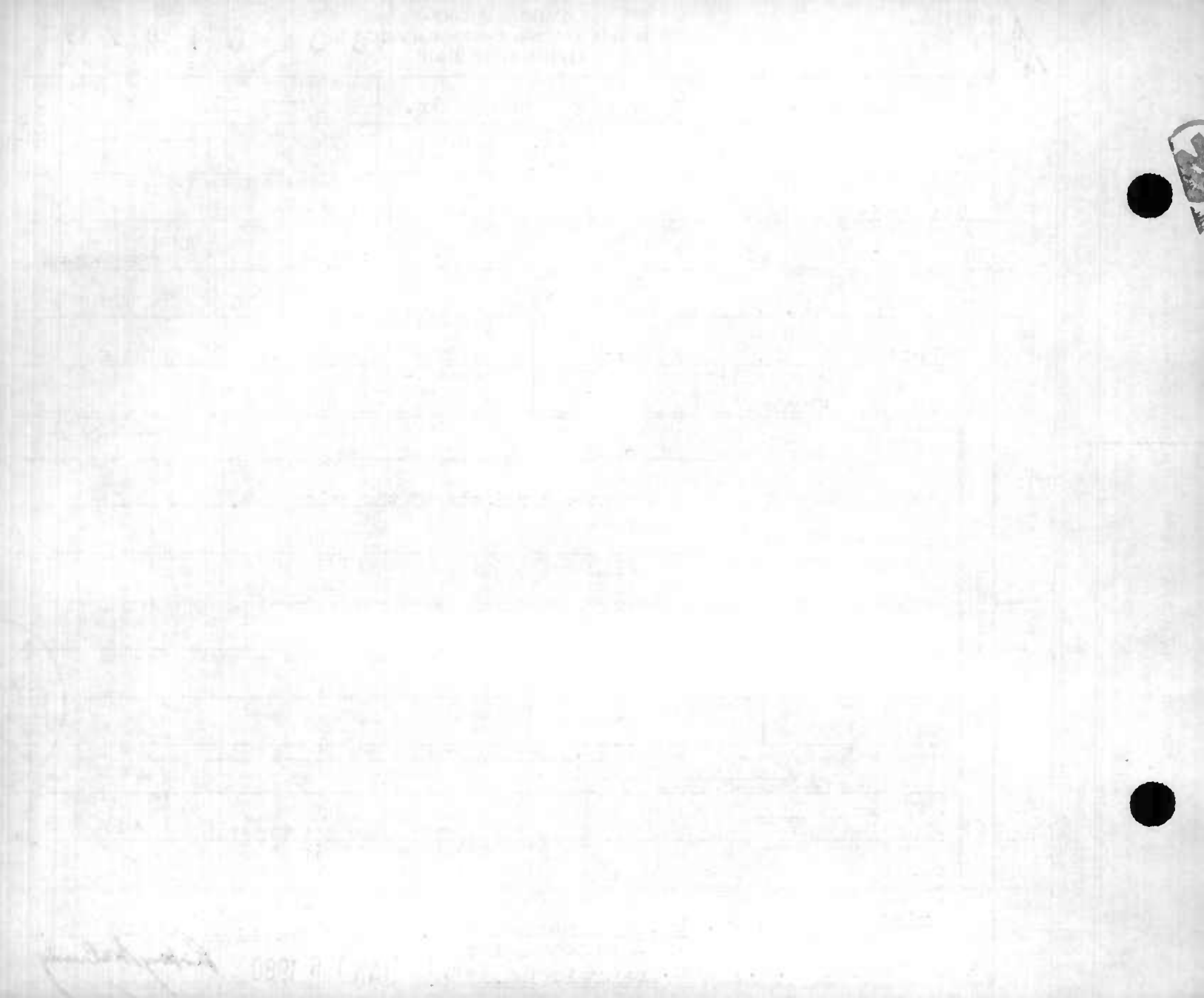
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |  |   |
|--|--|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Lester Eckard Sr.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 15, 1980 |   |   | 2b. HOUR<br>4:30 a.m.  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 28, 1931   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48<br>YRS.                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                        |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Clinical Center, NIH |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printing |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Printers  |  |   |   |   |   |  |   |
| 13a. STATE<br>Maryland   |  |   |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13c. STREET ADDRESS<br>3711 Kennedy Place                                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert L. Eckard   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa M. Hoover   |   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Korea  |  | 16b. SOCIAL SECURITY NO.<br>579-36-9199   |   | 17. INFORMANT<br>ADDRESS<br>Betty L. Eckard, wife, same   |   |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic carcinoma of the colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |  |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>26 November 79</u> to <u>15 January 80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>15 January 19 80</u> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |   |   |   |  |   |
| 22b. SIGNATURE<br><u>B. Foster</u>   |  | DEGREE<br><u>M.D.</u>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br><u>1/15/80</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BRENDA FOSTER M.D.</u>   |  |   |   | 22e. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md</u>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 18, 80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Emmanuel Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Scaggsville Howard Md.         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Fleck Laurel F.H., Inc.  |  | ADDRESS<br>Sandy Spring Rd. 7601  |   | DATE REC'D. BY REGISTRAR<br>JAN 16 1980   |   | REGISTRAR'S SIGNATURE<br><u>Kathy McBrady</u>                                |   |





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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |                                   |  |
|---|--|--|--|--|---|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  |  |   | 2b. HOUR   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |  |   | 2b. HOUR   |  |                                   |  |
| Viola   |  | Jan 19 80  |  |  |   | 11:25A   |  |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. UNDER 1 YEAR                   |  |
| FEMALE  |  | CAUCASIAN  |  | 9 MONTH 4 DAY 92   |   | 87 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                                   |  |
| Penna   |  | U.S.A.   |  |  |   | Montgomery MD.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Silver Spring   |  | Cherry Chase Nursing and Convalescent Center   |  |  |   | Housewife  |  | Home                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13b. INSIDE CITY LIMITS?  |  |  |                                   |  |
| Maryland  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                                   |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |  |
| Oliver  |  |  |  |  | Annie   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |                                   |  |
| None  |  |  |  |  | 578-62-7535   |  |  |                                   |  |
| 17. INFORMANT   |  |  |  |  | ADDRESS   |  |  |                                   |  |
| None  |  |  |  |  | Wash. D.C.  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |                                   |  |
| 436- Cerebral Vasc Accident   |  |  |  |  |   |  |  |                                   |  |
| 436- Hypertension   |  |  |  |  |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |                                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |   |  |  |                                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |   |  |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from  |  | 1970   |  | 1980   |   |  |  |                                   |  |
| saw the deceased alive on   |  | JAN-19   |  | 1980   |   |  |  |                                   |  |
| above, (I) (we) (did not) view the body after death.  |  |  |  |  |   |  |  |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN  |   | MEDICAL DIRECTOR   |  | STAFF PHYSICIAN                   |  |
| Robert Kramer   |  |  |  | <input checked="" type="checkbox"/>  |   | <input type="checkbox"/>                                       |  | <input type="checkbox"/>          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. DATE SIGNED   |   |  |  |                                   |  |
| ROBERT KRAMER   |  | 8630 FERTON RD SILVER SPRING   |  | 1/19/80  |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION  |  |                                   |  |
| Burial  |  | 1/24/80  |  | Grandview Cemetery   |   | Johnstown, Cambria, Pa.  |  |                                   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |                                   |  |
| NAME ADDRESS  |  | JAN 23 1980  |  | Trotter McCready   |   |  |  |                                   |  |
| W.W. Chambers Funeral Home Sil  |  |  |  |  |   |  |  |                                   |  |



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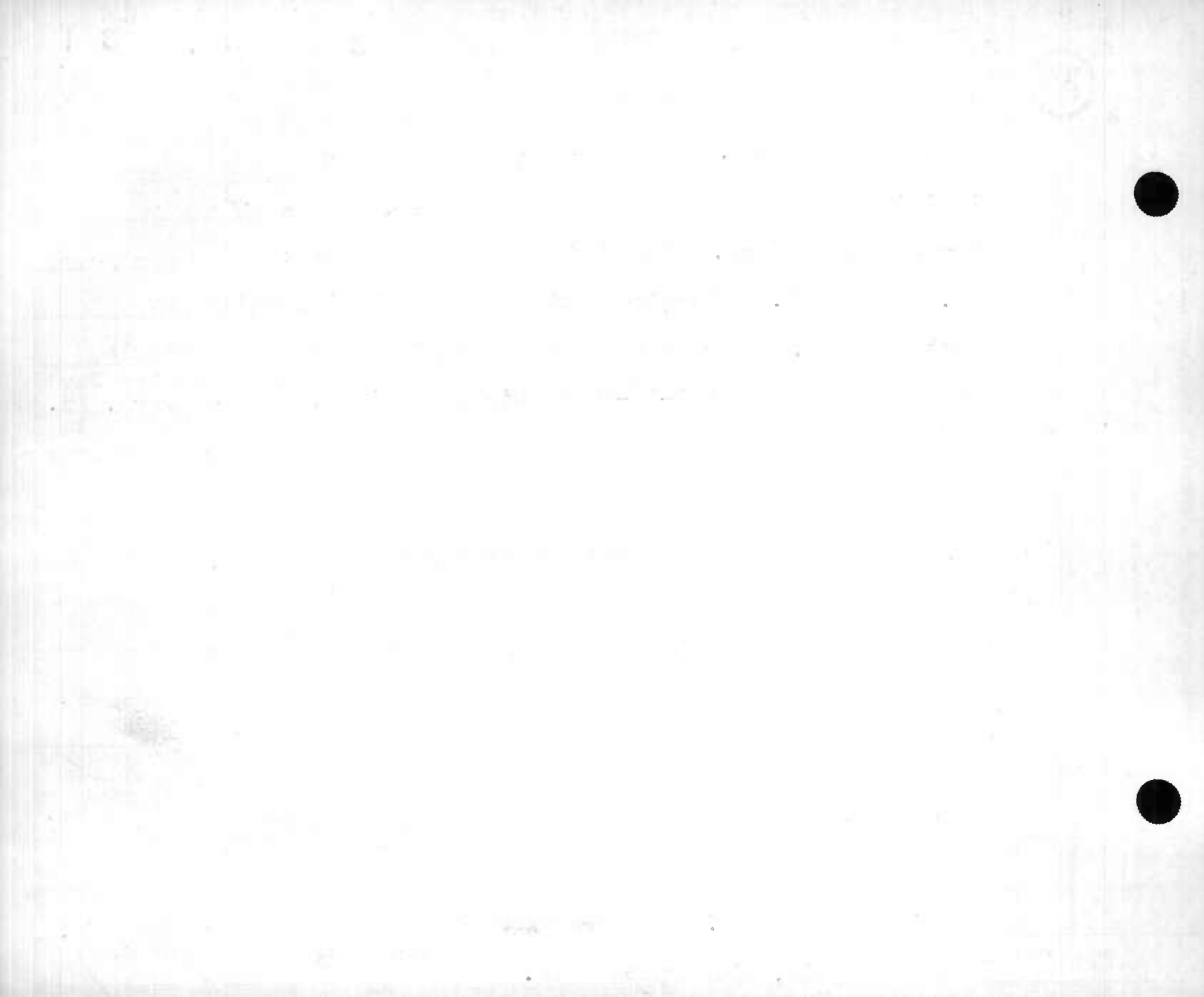
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |  |   |  |   | 8001981  |  |  |  |
|---|--|--|---|--|---|--|---|--|---|--|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |   |  |   |  |   |  |   |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Lyndall Roberta Evans</b>   |  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>Jan 11 80</b>                           |  |   |  | 2b HOUR<br><b>5<sup>23</sup> PM</b>   |  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Cauc.</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>5 18 13</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.                                |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont.</b> MD.                                  |   |  |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Tocoma Park</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wash. Adventist</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>      |   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>Mont.</b>   |   | 13c CITY OR TOWN<br><b>Langley Park</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 13e STREET ADDRESS<br><b>1803 Langley Way</b>  |   |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Treakle</b>   |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Treakle</b>          |  |   |  |   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |   | 16b SOCIAL SECURITY NO<br><b>573-34-1602</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>1803 Langley Way<br/>Shirley Mzingo, Langley Park, Md.</b> |   |  |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral As into 2<sup>o</sup></b><br><b>5716</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Biliary Cirrhosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mrs</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |   |  |   |  |  |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |  |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>1/11/80</b> to <b>1/11/80</b> , that (1) (we) lost sight of the deceased alive on <b>1/11/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |   |  |   |  |   |  |   |  |  |  |  |
| 22b SIGNATURE<br><b>David Cromwell md</b>   |  |  |   |  | DEGREE<br><b>MD</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>1/11/80</b>                            |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e ADDRESS   |  |   |  |   |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>1/14/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Claybrook</b>                         |  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Weems Lancaster Va.</b>  |   |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Elmore &amp; Haynie, Kilmarnock</b>   |  |  |   |  | ADDRESS<br><b>va.</b>   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Barry McCurdy</b>            |  |  |  |

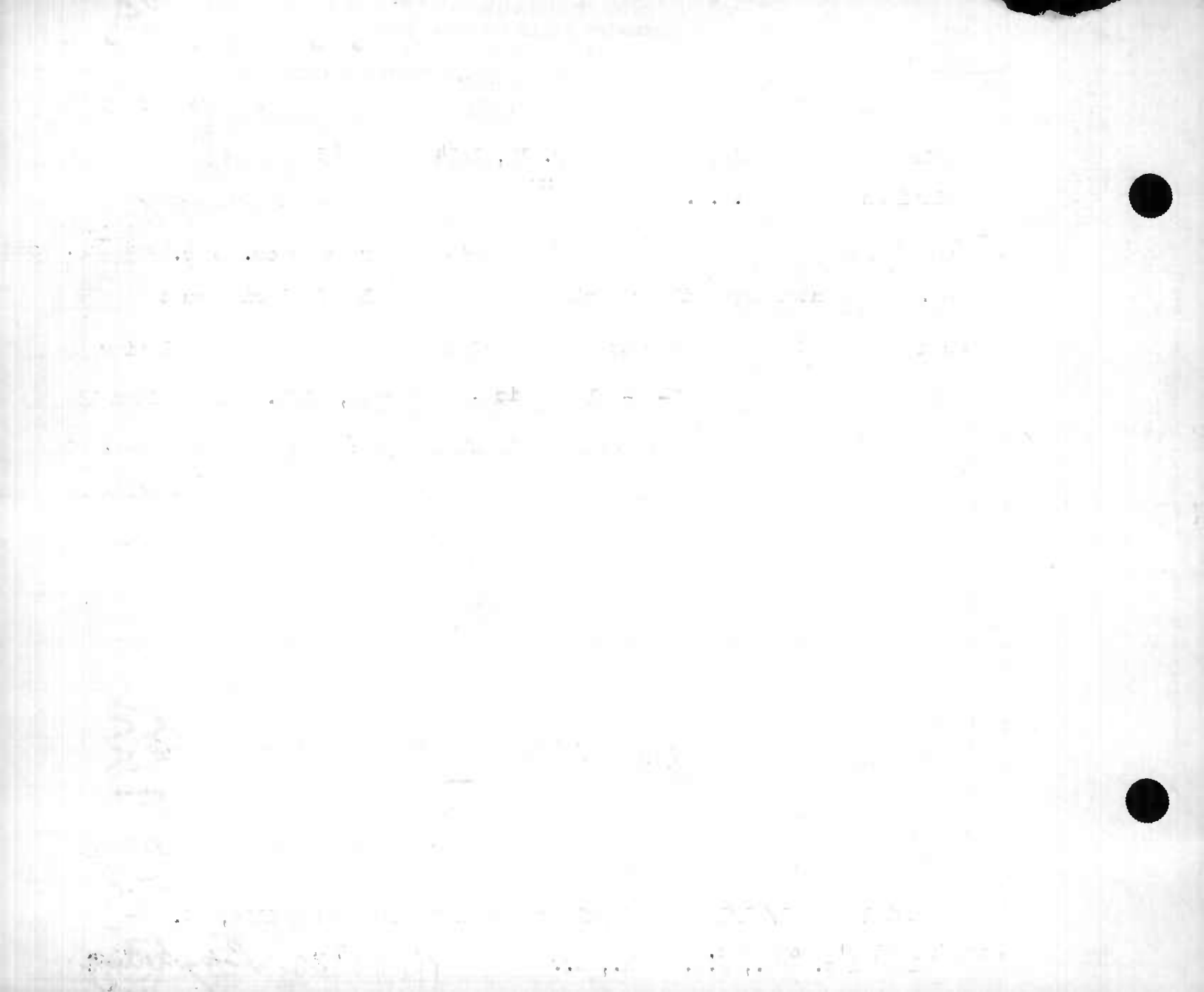


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                  |  |
|---|--|--|--|--|--|---|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8001782   |  |  |  |   |  |                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST ROBERTS  |  | MIDDLE   |  | LAST EVERETT  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  |
| Roberts   |  | Everett  |  |  |  | 1 28 80   |  | 2b. HOUR 5:50 A.M.               |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |
| Male  |  | White  |  | Mar. 17, 1894  |  | 85 YRS.   |  | HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                  |  |
| Michigan  |  | U.S.A.   |  |  |  | Montgomery MD.  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12c. FOOD SUP. ASSC.             |  |
| Silver Spring   |  | Holy Cross Hospital  |  | Trade Assoc. Exec.   |  | Food Sup. Assc.   |  |                                  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE  |  | 13c. COUNTY  |  | 13d. CITY OR TOWN  |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13f. STREET ADDRESS              |  |
| Md.   |  | Montgomery   |  | Silver Spring  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 12602 Eldrid Court               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                  |  |
| John E Everett  |  | Helen Glazier  |  |  |  |   |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                  |  |
| Yes   |  | WWI  |  | 057-03-2314  |  | Frieda W Everett, Wife. Same as item 13   |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  | 18b. DUE TO, OR AS A CONSEQUENCE OF (b)  |  | 18c. DUE TO, OR AS A CONSEQUENCE OF (c)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                  |  |
| 492- Respiratory failure  |  | Pneumonia  |  | Stroke, emphysema  |  | minutes   |  | 2 wks                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  | ASHD   |  |  |  |   |  |                                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16 1980 to 1/28 1980, that (I) (we) last saw the deceased alive on 1/28/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |
| Richard P. Delaney MD   |  | 4323 HARVARD ST SILVER SPRING, MD  |  |  |  |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                  |  |
| Burial  |  | 1/31/1980  |  | Parklawn Memorial Park   |  | Rockville, Md.  |  |                                  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                  |  |
| Joseph Gawler's Sons Inc.   |  | FEB 04 1980  |  | Ruthy McBratney  |  |   |  |                                  |  |
| 5130 Wisc. Ave., N.W. Wash., DC.  |  |  |  |  |  |   |  |                                  |  |





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8001983

|  |  |   |  |   |   |  |   |  |   |  |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATIE FAINGERG</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 22, 1980</b>            |   |   | 2b. HOUR<br><b>11:10AM</b>   |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 12 1886</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>NONE</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHEVY CHASE NSG + CONV CENTER</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |   |  |
| 13a. STATE<br><b>D. C.</b>   |  |   | 13b. COUNTY<br><b>NONE</b>   |   | 13c. CITY OR TOWN<br><b>WASHINGTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>524 QUACKENBOS STREET, N.W.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ITZHAK ROBBINS</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA (UNKNOWN)</b> |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-84-1604</b>                         |   | 17. INFORMANT<br><b>HAROLD FAINGERG</b> ADDRESS<br><b>14509 ELMHAN COURT, SILVER SPRING, MARYLAND</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DOE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Disease</b><br>DOE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> , 19 <b>80</b> , to <b>22 JAN 80</b> , that (I) (we) lost saw the deceased alive on <b>Jan 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert Kramer M.D.</b>  |  |   | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/23/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KRAMER, M.D.</b>  |  |   | 22e. ADDRESS<br><b>8630 PENTON ST. S.C. SPOND</b>                      |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>1/25/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON CEMETERY</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ADELPHI PR. GEORGES MD.</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>  |   |  |
| 23e. ADDRESS<br><b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>  |  |   |  |   |   |  |   |  |   |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |   |   |                  |  |                           |  |  |  |  | REG. NO. <b>01984</b>   |                           |
|--|----------------------|---|---|---|------------------|--|---------------------------|--|--|--|--|---|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William C. Ferro, Jr.</b>   |                      |   |   |   |                  |  |                           |  |  |  |  | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> <b>Jan 26 1980</b> | 2b. HOUR <b>6:24</b> P.M. |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Nov</b> DAY <b>14</b> YEAR <b>1932</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>47</b> YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD <b>Jan 26 1980</b>  | 2d. HOUR <b>6:24</b> P.M. |  |  |  |  |   |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |                           |  |  |  |  |   |                           |
| 10. CITY OR TOWN OF DEATH <b>Sol. Spg.</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Marketing Manager</b>       |                           | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |                           |
| 1. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| 13a. STATE <b>MD</b>   |                      | 13b. COUNTY <b>Mont.</b>  |   | 13c. CITY OR TOWN <b>Sol. Spg.</b>  |                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 13e. STREET ADDRESS <b>427 Branch Dr.</b>  |  |  |  |   |                           |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>C.</b> LAST <b>Ferro</b>   |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b>Baker</b> LAST <b>Baker</b>  |                  |  |                           |  |  |  |  |   |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |                      | 16b. SOCIAL SECURITY NO. <b>1952 - 1956 064-26-0179</b>   |   | 17. INFORMANT <b>wife Catherine L. Ferro</b>  |                  | ADDRESS <b>same as 13e</b>   |                           |  |  |  |  |   |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4391 Acute myocardial infarction</b>  |                      |   |   |   |                  |  |                           |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |                           |
| IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>   |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| <b>None</b>  |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| 19a. DATE OF OPERATION <b>None</b>   |                      |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |  |                           | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |                           |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |                           |  |  |  |  |   |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |  |  |  |   |                           |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |                      |   |   | TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER  |                  |  |                           | DATE SIGNED <b>Jan 26, 1980</b>  |  |  |  |   |                           |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |                      |   |   | ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>  |                  |  |                           |  |  |  |  |   |                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>Jan 29, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>  |                  |  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Mont Md.</b>      |  |  |  |   |                           |
| 24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>  |                      |   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1980</b>   |                  |  |                           | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |  |  |  |   |                           |
| 500 University Boulevard, W. Silver Spring, Md.  |                      |   |   |   |                  |  |                           |  |  |  |  |   |                           |

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Department" are faintly visible.]*

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR   |  |         |  |                  |  |                   |  |                |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |          |  |  |  |  |  | REG. NO. 01985   |  |  |  |                     |  |  |  |  |  |   |  |
|---|--|---------|--|------------------|--|-------------------|--|----------------|--|--|--|--------------------------|--|----------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         |  |                  |  |                   |  |                |  | FIRST MIDDLE LAST  |  |                          |  |          |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR   |  |                     |  |  |  |  |  |   |  |
| Evel F Finnin   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  | 6 MONTH DAY YEAR   |  | 12 M   |  |                     |  |  |  |  |  |   |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD |  | 7d. HOUR |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| M   |  | W       |  | April 28 1917    |  | 77 YRS.           |  |                |  |  |  | Jan 19 1980              |  | 8 M      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  |                  |  |                   |  |                |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                          |  |          |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                     |  |  |  |  |  |   |  |
| MASSACHUSETTS   |  |         |  |                  |  |                   |  |                |  | U. S. A.   |  |                          |  |          |  |  |  |  |  | Montgomery MD  |  |  |  |                     |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  |                  |  |                   |  |                |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |                          |  |          |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                     |  |  |  |  |  |   |  |
| Silver Spring   |  |         |  |                  |  |                   |  |                |  | Holy Cross Hospital  |  |                          |  |          |  |  |  |  |  | FEDERAL HOUSING  |  | GOVERNMENT   |  |                     |  |  |  |  |  |   |  |
| 13a. STATE  |  |         |  |                  |  |                   |  |                |  | 13b. COUNTY  |  |                          |  |          |  |  |  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS |  |  |  |  |  |   |  |
| MD  |  |         |  |                  |  |                   |  |                |  | Montgomery   |  |                          |  |          |  |  |  |  |  |  |  | 10201 Big Rock Rd  |  |                     |  |  |  |  |  |   |  |
| 14. FATHER'S NAME   |  |         |  |                  |  |                   |  |                |  | 15. MOTHER'S MAIDEN NAME   |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| THOMAS F  |  |         |  |                  |  |                   |  |                |  | ROSETTA  |  |                          |  |          |  |  |  |  |  | V  |  | SAUNDERS   |  |                     |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |         |  |                  |  |                   |  |                |  | 16b. SOCIAL SECURITY NO.   |  |                          |  |          |  |  |  |  |  | 17. INFORMANT  |  | ADDRESS  |  |                     |  |  |  |  |  |   |  |
| NO  |  |         |  |                  |  |                   |  |                |  | 578-24-3702  |  |                          |  |          |  |  |  |  |  | RUTH FINNIN  |  | SAME AS 13 WIFE  |  |                     |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |  |                   |  |                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| PART I DEATH WAS CAUSED BY:   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| 4291 IMMEDIATE CAUSE (a) Acute myocardial infarction  |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| (b) Gastrointestinal Hemorrhage   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| (c) Duodenal Ulcer  |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| Fracture Rt Hip   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |         |  |                  |  |                   |  |                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                          |  |          |  |  |  |  |  | 20. AUTOPSY?   |  |  |  |                     |  |  |  |  |  |   |  |
| Nov 10 79   |  |         |  |                  |  |                   |  |                |  | Fracture Rt Hip  |  |                          |  |          |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |                     |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |  |         |  |                  |  |                   |  |                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                          |  |          |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |                     |  |  |  |  |  |   |  |
|   |  |         |  |                  |  |                   |  |                |  | P.M. 1979  |  |                          |  |          |  |  |  |  |  | Fall going to bath room  |  |  |  |                     |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |  |                  |  |                   |  |                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                          |  |          |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |                     |  |  |  |  |  |   |  |
|   |  |         |  |                  |  |                   |  |                |  | Hospital   |  |                          |  |          |  |  |  |  |  | Forest Glen Rd Silver Spring Mont. Md  |  |  |  |                     |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  |         |  |                  |  |                   |  |                |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE  |  |         |  |                  |  |                   |  |                |  | TITLE (SPECIFY)  |  |                          |  |          |  |  |  |  |  | DATE SIGNED  |  |  |  |                     |  |  |  |  |  |   |  |
| John Rogers   |  |         |  |                  |  |                   |  |                |  | M.D. Dep.  |  |                          |  |          |  |  |  |  |  | MEDICAL EXAMINER   |  | Jan 19 1980  |  |                     |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |                  |  |                   |  |                |  | ADDRESS  |  |                          |  |          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |   |  |
| JOHN ROGERS   |  |         |  |                  |  |                   |  |                |  | 1919 SEMINARY RD.  |  |                          |  |          |  |  |  |  |  | SILVER SPRING, MD.   |  |  |  |                     |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |                  |  |                   |  |                |  | 23b. DATE  |  |                          |  |          |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |                     |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| BURIAL  |  |         |  |                  |  |                   |  |                |  | 1/22/80  |  |                          |  |          |  |  |  |  |  | CEDAR HILL CEMETERY  |  |  |  |                     |  |  |  |  |  | SUITLAND                                |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |  |                  |  |                   |  |                |  | 25a. DATE REC'D. BY REGISTRAR  |  |                          |  |          |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                     |  |  |  |  |  |   |  |
| FRANCIS J. COLLINS  |  |         |  |                  |  |                   |  |                |  | JAN 22 1980  |  |                          |  |          |  |  |  |  |  | P. GEO. MD.  |  |  |  |                     |  |  |  |  |  |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |         |  |                  |  |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  | JAN 22 1980  |  |  |  |                     |  |  |  |  |  |   |  |

U.S. GOVERNMENT PRINTING OFFICE: 1964 O - 354-100

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marvin F. FISHER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14 1980</b>          |   |  | 2b. HOUR<br><b>11:00P</b>  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 6 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U. S. Navy</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>                                       |   | 13c. CITY OR TOWN<br><b>Rockville</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br><b>14403 Briarwood Terrace</b>   |  |   |  |   |  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herman Fisher</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Braun</b>   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1940-1961</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Pauline Fisher See item 13</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC ADENOCARCINOMA OF UNKNOWN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PRIMARY SOURCE</b>                                       |  |   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I/ (this hospital)) attended the deceased from <b>May 79</b> , to <b>Jan. 14</b> , 19 <b>80</b> , that I/ (we) lost<br>saw the deceased alive on <b>Jan. 14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/ (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>S.J. Chobanian</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Jan. 15 1980</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S.J. Chobanian Lt/mc/USNR</b>   |  |   | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md</b>     |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/18/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Virginia</b>                        |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tyson Wheeler Funeral Home, Inc.</b><br>ADDRESS<br><b>1331 Rockville Pike Rockville, Maryland 20852</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |                   |  |   |                   |  |  |  |
|--|--|--|--|---|-------------------|--|---|-------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8001987  |  | REG. NO.  |                   |  |   |                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |   |                   | 2a. DATE OF DEATH  |   |                   | MONTH DAY YEAR   |  |  |
| Theresa K. Flynn   |  |  |  |   |                   | Jan. 31, 1980  |   |                   | 8 39/4 M   |  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |                   | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7 IF UNDER 1 YEAR |  | 8 IF UNDER 24 HRS  |  |
| Female   |  | White  |  | Oct. 6 1890   |                   | 89 yrs.  |   | MONTHS DAYS       |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                   |  |  |  |
| Mo.  |  | U.S.A.   |  |   |                   | Montgomery MD  |   |                   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   |                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| Rockville  |  | Potomac Valley Nursing Home  |  |   |                   | Housewife  |   |                   | Home   |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN |  | 14. INSIDE CITY LIMITS?   |                   | 15. STREET ADDRESS   |  |  |
| Md.  |  |  | Montgomery   |   | Chevy Chase       |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 5200 Murray Rd.  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |   |                   | 16b. SOCIAL SECURITY NO.                                       |  |  |
| David  |  |  | Kinealy  |   |                   | Mary   |   |                   | Flynn  |  |  |
| 17. INFORMANT  |  |  | 18. ADDRESS  |   |                   | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)               |   |                   | 20. SOCIAL SECURITY NO.  |  |  |
| Mary Corrigan  |  |  | Same as 13e  |   |                   | No   |   |                   | 487-18-6550  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal cerebral thrombosis</u><br><u>4340</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>—</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u> |  |  |  |   |                   |  |   |                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Yes</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>—</u>  |  |  |  |   |                   |  |   |                   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                   | 20a. AUTOPSY?  |   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23/80</u> 19 <u>80</u> , to <u>1/31/80</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>1/23/80</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |                   |  |   |                   |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |   |                   | 22c. DATE SIGNED   |   |                   |  |  |  |
| <u>OSONT LERAGOL</u>   |  |  |  |   |                   | 1/31/80  |   |                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |   |                   | 23a. LOCATION  |   |                   | 23b. COUNTY  |  |  |
| OSONT LERAGOL  |  |  | 7455 arlington Rd, Beltsville Md                                       |   |                   | St. Louis  |   |                   | St. Louis Mo.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   |                   | 23d. LOCATION  |  |  |
| Burial   |  |  | 2/2/80   |   |                   | Calvary Cemetery   |   |                   | St. Louis Mo.  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  | 24b. ADDRESS   |   |                   | 25a. DATE REC'D BY REGISTRAR   |   |                   | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| Tyson Wheeler Funeral Home   |  |  | 1331 Rockville Pk. Rockville, Md.                                      |   |                   | 1/31/80  |   |                   |  |  |  |





Theresa Lynn

1930 88 yrs. 6 1930

U.S.A. x

Macville Before Valley turning home

1930 88 yrs. 6 1930

David Kinsley

1930 88 yrs. 6 1930

x

1930 88 yrs. 6 1930  
1930 88 yrs. 6 1930  
1930 88 yrs. 6 1930

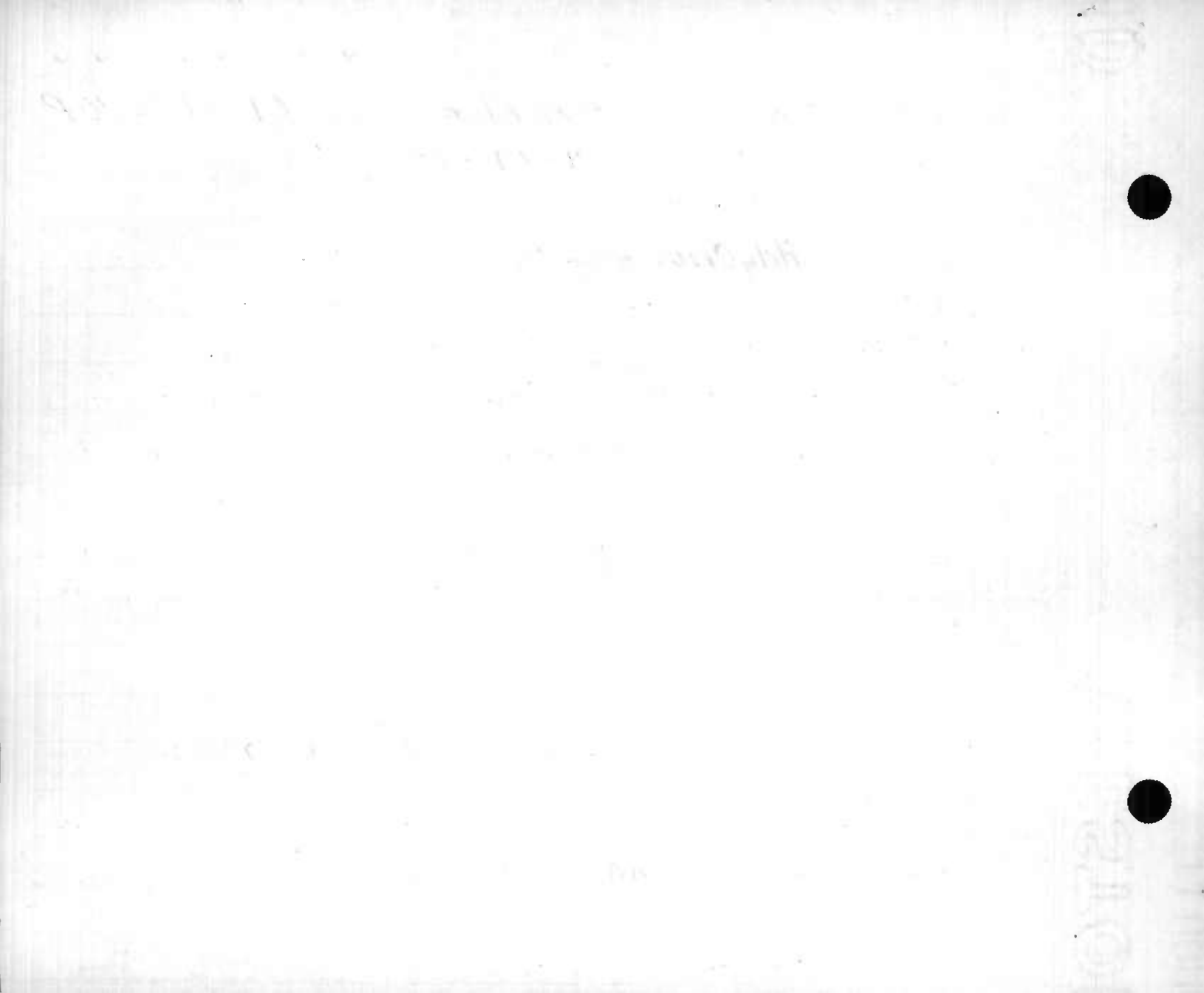


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8001988  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Hampton A. Franklin</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>01-27-80</i>   |  | 2b. HOUR<br><i>10 P.M.</i>  |  |
| 3. SEX<br><i>M</i>  |  | 4. RACE<br><i>N</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4-07-05</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><i>74</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Va.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Mont.</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>S.S. Mont. Ct. Ind.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Holy Cross Hospital</i>        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Laborer</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><i>Mont. Yakoma Park</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>780 Laurview Ave.</i>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Samuel Franklin</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary Franklin</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, INDICATE UNKNOWN) <i>UNK</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>Unk</i>   |  | 17. INFORMANT ADDRESS<br><i>Mrs. Claudia W. Franklin/wife/same as 13e</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Renal Failure</i><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Diabetes mellitus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 months</i><br><i>years</i> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Parkinsonism Right Liver Lobe Abscesses Sinusitis</i>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> , 19 <i>79</i> , to <i>1/27</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>1/27</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Alan W. Weinstock</i>  |  |  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>1/28/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Alan W. Weinstock MD</i>  |  |  |  | 22e. ADDRESS<br><i>1759 Lumberton Dr Silver Spring MD</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2-2-80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Church</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Lynchburg, Va.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>John T. Rhines Co., 3015 12th St., N.E., D.C.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 4 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>  |  |



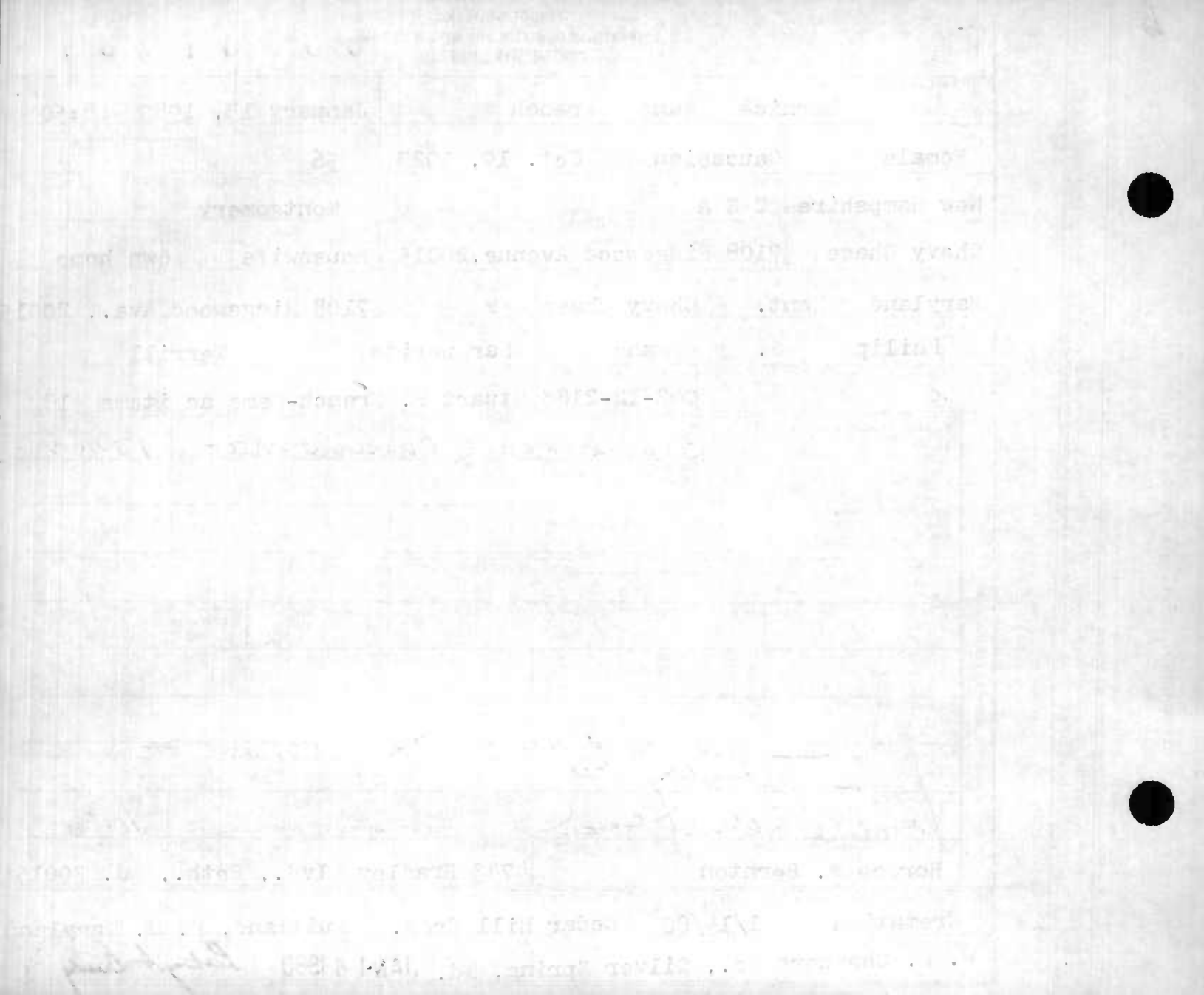
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |                                  |  |   |  |
|--|--|---|--|---|---|--|----------------------------------|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  | 8001989<br>REG. NO.   |  |   |   |  |                                  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bernice Rand French   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 13, 1980             |  |                                  | 2b. HOUR P.<br>8:50 M  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 19, 1923   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS  |                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Hampshire   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7108 Ridgewood Avenue, 20015 |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own home  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Chevy Chase |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Philip S. Rand   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marguerite Merrill |  |                                  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>002-12-2188   |  | 17. INFORMANT<br>ADDRESS<br>Stuart P. French-Same as items #13  |   |  |                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma -</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 mos. - |  |   |  |   |   |  |                                  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |  |                                  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 12</u> , 19 <u>80</u> , to <u>13 Jan</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>12 Jan</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |   |  |   |   |  |                                  |  |   |  |
| 22b. SIGNATURE<br><u>Horace W. Bernton</u><br>DEGREE   |  |   |  |   | 22c. DATE SIGNED<br>1/14/80   |  |                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Horace W. Bernton   |  |   |  |   | 22e. ADDRESS<br>4743 Bradley Blvd., Beth., Md. 20015                |  |                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/14/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P. G. Maryland               |                                  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. Chambers Co., Silver Spring, Md.   |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>P. G. Chambers</u>                 |  |                                  |  |   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |                                       |  |   |  |  |
|--|--|---|--|---|---|---|---------------------------------------|--|---|--|--|
| 1. FOR<br>STATE REGISTRAR  |  |   |  |   | REG. NO. 8001990  |   |                                       |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRACE - FRENCH</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1 21 80</b>  |   |                                       |  |   | 2b. HOUR<br><b>6<sup>50</sup> P.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASION</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 -14-1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 7. IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Dakota</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |                                       |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SANDY SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRIEND HOUSE NINOME</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supv. Cafeteria</b>  |                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mtgy. Co. Sch</b> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Sandy Sprg</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>Unknown</b> |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Fenton</b>                          |   |                                       |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>William French 8303 Winder St. Vienna, Va.</b>   |   |   |                                       |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per part for (a) only, and (b) IMMEDIATE CAUSE (a)<br><b>4292 Cardiorespiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ABRUPT CARDIAC DEATH</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>ABRUPT CARDIAC DEATH</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ABRUPT CARDIAC DEATH</b>   |  |   |  |   |   |   |                                       |  |   | APPROXIMATE PERIOD BETWEEN DEATH AND 180<br><b>3 days</b><br><b>8 days</b><br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Obstructive Pulmonary Disease, Chronic Bronchitis, Emphysema</b>   |  |   |  |   |   |   |                                       |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                       |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                       |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/78</b> to <b>1/21/80</b> , that (I) <del>was</del> lost saw the deceased alive on <b>1/18/80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the cause stated above (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |  |   |  |   |   |   |                                       |  |   |  |  |
| 22b. SIGNATURE<br><b>C. H. L. [Signature]</b>  |  | 22c. DEGREE   |  | 22d. DATE SIGNED<br><b>1/21/80</b>  |   | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       |  |   |  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. H. L. [Signature]</b>   |  | 22g. ADDRESS<br><b>18111 P. Philip Dr., Chevy Chase 20832</b>   |  |   |   |   |                                       |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan 24/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland DC Co. Maryland</b>   |                                       |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chambers Funeral Home</b>   |  | ADDRESS<br><b>Riverdale, Maryland</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                       |  |   |  |  |

BP

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |                  |                                      |                          |   |          | REC. NO. 01991 |  |
|--|---------|--|--|---|------------------|--------------------------------------|--------------------------|---|----------|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |                  | LAST                                 |                          | 2a. DATE KNOWN OF DEATH   |          | 2b. HOUR       |  |
| Thomas   |         | J.   |  | Fritz   |                  |                                      |                          | X 1 10 19 80  |          | M              |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   | IF UNDER 24 HRS. |                                      | 2c. DATE PRONOUNCED DEAD |   | 2d. HOUR |                |  |
| Male   | White   | April 18 92  |  | 87 YRS.   |                  |                                      | 1 10 19 80               |   | 7:50A    |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                          |   |          |                |  |
| Wash. D.C.   |         | USA  |  | WIDOWED X NEVER MARRIED DIVORCED                              |                  | Montgomery County, MD.               |                          |   |          |                |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                  | 12b. KIND OF BUSINESS OR INDUSTRY    |                          |   |          |                |  |
| Silver Spring  |         | Colonial Villa Nursing Home                              |  | Railroad-Railway Express                                      |                  |                                      |                          |   |          |                |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS?             |                          | 13e. STREET ADDRESS   |          |                |  |
| Md.  |         | Mont.  |  | S.S.  |                  | YES X NO                             |                          | 12325 N.H.Ave.S.S.Md.   |          |                |  |
| 14. FATHER'S NAME  |         |  |  | 15. MOTHER'S MAIDEN NAME                                      |                  |                                      |                          |   |          |                |  |
| UNK  |         |  |  | UNK   |                  |                                      |                          |   |          |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |  |  | 16b. SOCIAL SECURITY NO.                                      |                  |                                      |                          | 17. INFORMANT   |          |                |  |
| No   |         |  |  | 718 18 7999A  |                  |                                      |                          | Same as above (Address) Villa)  |          |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |                  |                                      |                          | INTERVAL AND DEATH  |          |                |  |
| PART 1 DEATH WAS CAUSED BY:  |         |  |  |   |                  |                                      |                          |   |          |                |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |   |                  |                                      |                          |   |          |                |  |
| 4292   |         |  |  |   |                  |                                      |                          |   |          |                |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |  |  |   |                  |                                      |                          |   |          |                |  |
| (b)  |         |  |  |   |                  |                                      |                          |   |          |                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                  |                                      |                          |   |          |                |  |
| (c)  |         |  |  |   |                  |                                      |                          |   |          |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |                  |                                      |                          |   |          |                |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                  |                                      |                          | 20. AUTOPSY?  |          |                |  |
|  |         |  |  |   |                  |                                      |                          | YES X NO  |          |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY   |                  |                                      |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |          |                |  |
|  |         |  |  | HOUR A.M. MONTH DAY YEAR                                      |                  |                                      |                          |   |          |                |  |
| 21d. INJURY OCCURRED   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  |                                      |                          | 21f. LOCATION   |          |                |  |
| WHILE AT WORK NOT WHILE AT WORK  |         |  |  |   |                  |                                      |                          | CITY OR TOWN COUNTY STATE   |          |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner. |         |  |  |   |                  |                                      |                          |   |          |                |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |                  |                                      |                          | DATE SIGNED   |          |                |  |
| R. H. Fisher MD  |         |  |  | M.D. Deputy Chief   |                  |                                      |                          | 1/10/80   |          |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |                  |                                      |                          |   |          |                |  |
| for Thomas D. Smith, M.D.  |         |  |  | 111 Penn St. Balto., MD.                                      |                  |                                      |                          |   |          |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION   |          |                |  |
| Burial   |         |  |  | 1/14/80   |                  | Rock Creek Cemetery                  |                          | Wash. D.C.  |          |                |  |
| 24. FUNERAL DIRECTOR   |         |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |                  |                                      |                          | 25b. REGISTRAR'S SIGNATURE  |          |                |  |
| NAME ADDRESS   |         |  |  | 1/16/1980   |                  |                                      |                          | History & Beauty  |          |                |  |
| Hines/Rinaldi F.H. 11800 N.H.Ave.S.S.Md.   |         |  |  |   |                  |                                      |                          |   |          |                |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS RELEASED TO THE MEDICAL EXAMINER. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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FEDERAL BUREAU OF INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |  |   | REG. NO. 8001992   |  |
|--|--|--|---|---|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR <i>Clara</i>  |  |  |   |   |  |  |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Clara M Fullington</i>  |  |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1/3/80</i>                                |   |  | 2b. HOUR<br><i>7:00 P.M.</i>  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>2 13 93</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.                                |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                    |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Suburban Hospital</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homeaker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>                       |   |  |  |
| 13a. STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY<br><i>Montgomery</i>                                    |   | 13c. CITY OR TOWN<br><i>Potomac</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>11101 Bellavista Drive</i>  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Unknown Fullington</i>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Unknown</i>  |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO<br><i>577 40 1052A</i>   |   | 17. INFORMANT ADDRESS<br><i>Anne F. Douglass same as 13e</i>  |  |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Subarachnoid Sub Dural Hemorrhage</i><br><i>2050</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombocytopenia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Myelogenous Leukemia</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>1 month</i><br><i>2-3 months</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Hypertension Renal Stone</i>   |  |  |   |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 3</i> , 19 <i>79</i> , to <i>Jan.</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3 Jan</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Eugene P. Libre M.D.</i>  |  |  |   |   |  | DEGREE<br><i>M.D.</i>  |   |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eugene P. Libre M.D.</i>   |  |  |   |   |  | 22e. ADDRESS<br><i>10410 Conn. Ave. Kensington Md. 20795</i>                     |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |  |  | 23b. DATE<br><i>1/5/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Metropolitan Crematory</i>            |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Alexandria, Virginia</i> |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Tyson Wheeler Funeral Home, Inc.</i>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1980</i>                               |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |
| 1331 Rockville Pike Rockville, Md. 20852   |  |  |   |   |  |  |   |  |   |  |  |



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## Background

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1031 West Virginia Ave. 1031 West Virginia Ave. 1031 West Virginia Ave.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. <b>01993</b>   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lillian A. Gabel</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR OF ESTI. MATED <input type="checkbox"/> <b>Jan 28 1980</b> <b>6:30</b> M |  |
| 3. SEX <b>F</b> 4. RACE <b>W</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>July 5, 04</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>Jan 28 1980</b> <b>8:30</b> M                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH <b>St. Louis</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Mont</b> 13b. COUNTY <b>St. Louis</b> 13c. CITY OR TOWN <b>St. Louis</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>ADAMS DRIVE</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>EMIL PAGE</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN ELRICH</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>219-48-9094</b> 17. INFORMANT <b>CARL W. GABEL, JR.</b> ADDRESS <b>SAME AS 13</b> SON  |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }<br>(c) }<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                      |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>Dep.</b> TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER DATE SIGNED <b>Jan 28 1980</b>   |  |  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b> ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>1/31/80</b> 23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b> 23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b> COUNTY <b>MONT</b> STATE <b>MD.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1980</b> 25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, M D. 20901  |  |  |  |  |  |  |  |  |  |   |  |

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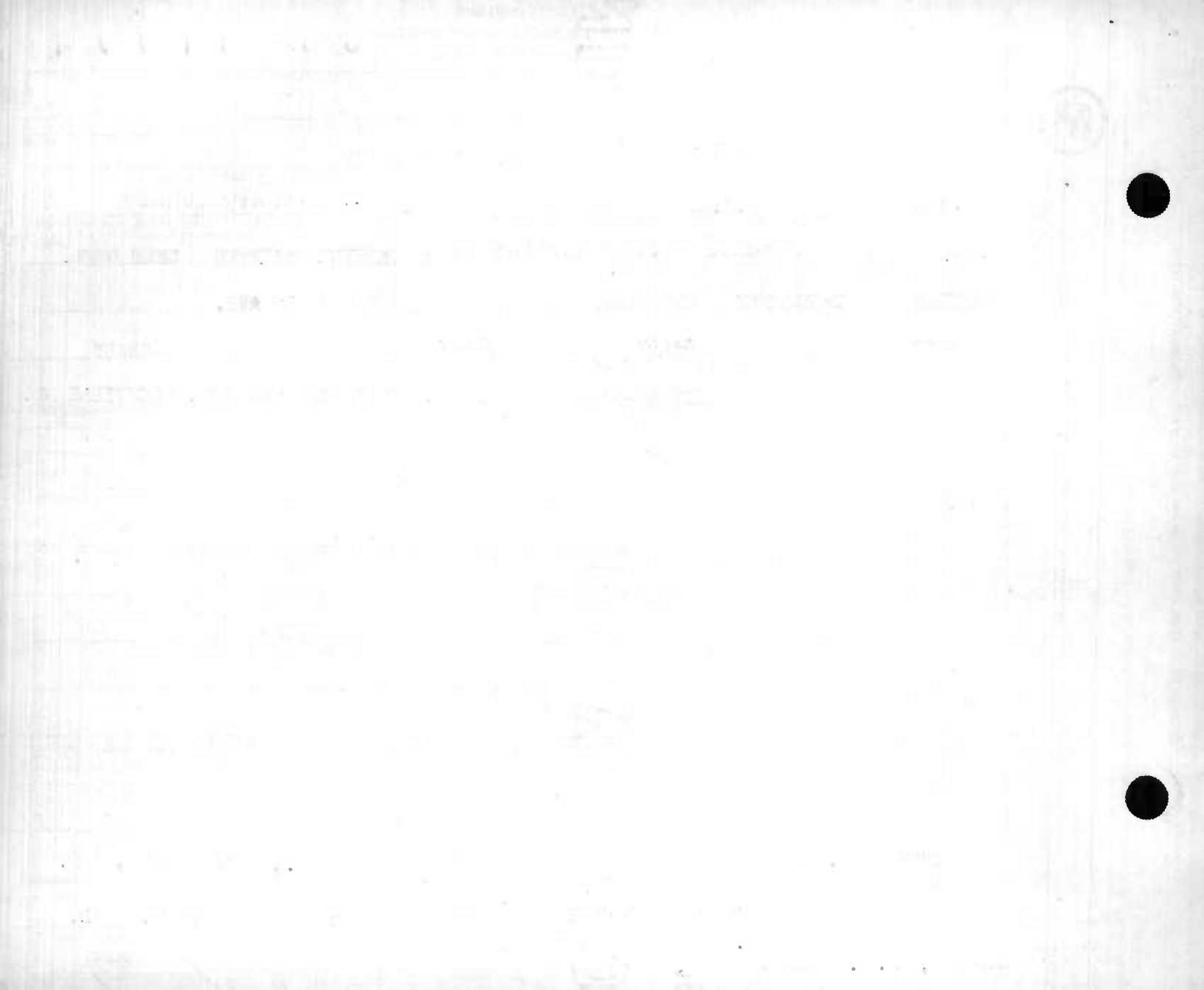


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 0 0 1 9 9 4  |  |                                   |   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|-----------------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |  |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HIRAM C GANDY   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/31/80                         |   |  |  |  | 2b. HOUR<br>12:25 AM   |  |                                   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 19 1906   |  |   | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br>73 YRS.                               |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.              |  |  |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED PAINTER  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPL. |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>ROCKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>804 MAPLE AVE.  |  |  |  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD GANDY   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORA GRADY           |   |  |  |  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-12-5855 |   | 17. INFORMANT<br>ADDRESS<br>RICHARD C. GANDY 812 WADE AVE., ROCKVILLE, MD. |  |  |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respir. arrest</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Myocardial Infarction</u><br>(c) <u>Coronary arteriosclerosis</u> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15'<br>15'<br>5 days   |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Tuber dorsalis - Charcot jkt. &amp; Tremor</u>  |  |  |  |   |  |   |  |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/1952</u> to <u>1/31/1980</u> , that (I) (we) last saw the deceased alive on <u>1/17/1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |  |   |  |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br><u>Stephen N. Jones</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  |   |  |  |  | 22c. DATE SIGNED<br>1/31/80  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEPHEN N. JONES  |  |  |  |   | 22e. ADDRESS<br>809 Viers Mill Rd., Rockville, Md.                     |   |  |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>1-23-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ROCKVILLE CEMETERY  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROCKVILLE MONTG. MD.   |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1980  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Gregory McBrady</u>   |  |                                   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |  |   |  |   |  |  |  | REG. NO. 01995  |  |                   |  |
|--|--|--------------|--|---|--|---|--|---|--|--|--|---|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Danna XANA Michelle GATTON  |  |              |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 19 80      |  | 2b. HOUR<br>8:46a   |  |                   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 22 64   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>15 YRS.                     |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 19 80                               |  | 2d. HOUR<br>8:46a |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |
| 13a. STATE<br>Maryland   |  |              |  | 13b. CITY OR TOWN<br>Hollywood  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br>Box 61   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel William Gatton, Sr.   |  |              |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Jean Bowles |  |   |  |  |  |   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |              |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br>Daniel Wm. Gatton  |  |  |  | ADDRESS<br>Same as 13e.   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Aspiration Vomitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |              |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Mental &amp; Physical Retardation</u>  |  |              |  |   |  |   |  |   |  |  |  |   |  |                   |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><u>P.A. 1/18/80</u>  |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.A. 1/18/80</u>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>Unintended and Asphyxiated</u>  |  |  |  |   |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><u>Center for Retarded Randolph Rd. S. Laps Mount Air</u>          |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>Center for Retarded Randolph Rd. S. Laps Mount Air</u>  |  |  |  |   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |  |   |  |   |  |   |  |  |  |   |  |                   |  |
| ACTUAL SIGNATURE<br><u>John S. Rogers</u>  |  |              |  | TITLE (SPECIFY)<br><u>MD</u>  |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br><u>Jan 19 1980</u>   |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |              |  | ADDRESS   |  |   |  |   |  |  |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |              |  | 23b. DATE<br>1/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Johns Cem.              |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hollywood St. Mary's Md. |  |   |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley   |  |              |  |   |  | ADDRESS<br>Leondtown, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980                           |  | 25b. REGISTRAR'S SIGNATURE<br><u>John S. Rogers</u>                                 |  |                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO. 8001996   |  |   |  |
|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM</b> <b>CHARLES</b> <b>GEORGE</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 31 80</b> 2b. HOUR<br><b>4:45</b> M                  |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 30 24</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>55</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS)<br><b>SUBURBAN</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>335 Dean Drive</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Charles George, Sr.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Wilson</b>                             |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WW II</b>  |  | 16b. SOCIAL SECURITY NO<br><b>577 38 8556</b>   |  | 17. INFORMANT ADDRESS<br><b>Myrtle F. George same as 13e</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Exsanguination</b><br><b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Secondary to Chronic Gastro Intestinal</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <b>Hemorrhaging</b> |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 28</b> , 19 <b>25</b> , to <b>Jan 31</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Jan 31</b> , 19 <b>80</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>William F. Luckett</b> MD  |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-1-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William F. Luckett</b>  |  |   |  | 22e. ADDRESS<br><b>5000 Reno Rd. Washington, D.C. N.W</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/5/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Pyson Wheeler Funeral Home, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Dietrich McCarty</b>  |  |   |  |
| 1331 Rockville Pike Rockville, Md. 20852  |  |   |  |   |   |  |  |   |  |

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1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                                    |  |   |                                      |  | REG. NO. 80 01997                            |            |  |
|--|--|--|---|--|------------------------------------|--|---|--------------------------------------|--|--|------------|--|
| 1. FOR STATE REGISTRAR   |  |  | I. DECEASED NAME (TYPE OR PRINT)                                    |  |                                    |  | 2a. DATE OF DEATH   |                                      | 2b. HOUR   |  |            |  |
|  |  |  | Hyman Gerson  |  |                                    |  | JANUARY 14/80   |                                      | 353 A.M.   |  |            |  |
| 3 SEX  |  | 4 RACE   |   | 5. DATE OF BIRTH   |                                    | 6 AGE [IN YEARS (LAST BIRTHDAY)]   |   | 7. IF UNDER 1 YEAR                   |  | 7. IF UNDER 24 HRS                           |            |  |
| Male   |  | WHITE  |   | 12 19 94   |                                    | 85 YRS.  |   | MONTHS                               |  | DAYS   |            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                                      |  |  |            |  |
| Russia   |  | U. S. A.   |   |  |                                    | Montgomery   |   |                                      |  |  |            |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |            |  |
| Rockville  |  | Shady Grove Advent. Hosp.  |   |  |                                    | Telegraph Operator   |   | WESTERN                              |  |  |            |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |                                      | 13e. STREET ADDRESS  |  | 13f. UNION |  |
| MARYLAND   |  |  | Prince George   |  | Hyattsville                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 6619 Stanton Rd.   |  |            |  |
| 14 FATHER'S NAME   |  |  |   | 15 MOTHER'S MAIDEN NAME  |                                    |  |   |                                      |  |  |            |  |
| Benjamin   |  |  |   | Unascertainable  |                                    |  |   | Bessie                               |  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   | 16b. SOCIAL SECURITY NO.   |                                    | 17 INFORMANT   |   | ADDRESS                              |  |  |            |  |
| Yes  |  |  |   | WW-1   |                                    | 578-09-0919  |   | Mrs. Beverly Z. Miles Same as No. 13 |  |  |            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                    |  |   |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |            |  |
| IMMEDIATE CAUSE (a) Cardiac pulmonary arrest   |  |  |   |  |                                    |  |   |                                      |  | 36 hrs                                       |            |  |
| 9/12- DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| (b) Asphyxia   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| (c) Choking on foreign object  |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| ASHD   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    |  | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |            |  |
|  |  |  |   |  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                                      |  |  |            |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |   |                                      |  |  |            |  |
|  |  |  | P.M. 19   |  |                                    |  |   |                                      |  |  |            |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |   |                                      |  |  |            |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |   |  |                                    | CITY OR TOWN COUNTY STATE  |   |                                      |  |  |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12 19 80, to 1/14 19 80, that (I) (we) last saw the deceased alive on 1/14 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death. |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| 22b. SIGNATURE   |  |  |   |  |                                    | DEGREE   |   |                                      | 22c. DATE SIGNED   |  |            |  |
| Peter B. Sherer MD   |  |  |   |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                                      | 1/14/80  |  |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |                                    | 22e. ADDRESS   |   |                                      |  |  |            |  |
| Peter B. Sherer MD   |  |  |   |  |                                    | 6410 Rockledge Dr. #308 Bethesda, Md. 20034  |   |                                      |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION   |                                      |  |  |            |  |
| Burial   |  |  | 1/15/80   |  | King David Memorial Garden         |  | Falls Church, Virginia  |                                      |  |  |            |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| Donald M. Stein Hebrew Memorial F. H. 232 Carroll Street, N. W. Washington, D. C.  |  |  |   |  |                                    |  |   |                                      |  |  |            |  |
| JAN 17 1980  |  |  |   |  |                                    |  |   |                                      |  |  |            |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |                    | REG. NO. 80 01998   |  |
|--|--|--|--|---|--|---|--|---|--------------------|---|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ALFRED V. GIDDINGS  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>1-30-80                                    |  |   | 2b HOUR<br>12:45 M |   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10-28-1903  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS                                      |  | IF UNDER 1 YEAR MONTHS DAYS   |                    | IF UNDER 24 HRS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MONT. CO   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTECENELY MD.                        |  |   |                    |   |  |
| 10 CITY OR TOWN OF DEATH<br>KENSINGTON MD  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KENSINGTON GARDEN NURSING H. |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARPENTER     |  | 12b KIND OF BUSINESS OR INDUSTRY  |                    |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>SS. MD   |  |  |  | 13b COUNTY<br>MONT.   |  | 13c CITY OR TOWN<br>SILVER SPRING   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                    | 13e STREET ADDRESS<br>2311 GLENALLEN AVE APT 201  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>BENJAMIN GIDDINGS  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARGARET COBURN  |  |   |  |   |                    |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |  |  | 16b SOCIAL SECURITY NO.<br>578-14-1307A   |  | 17 INFORMANT ADDRESS<br>BETTY HEFLIN, 1200 SPOTSWOOD DR. SS. MD               |  |   |                    |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerosis</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF <u>cardiovascular disease</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |   |                    |   |  |
| 19a DATE OF OPERATION  |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                    | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |                    |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |                    |   |  |
| 22a I certify that I (this hospital) attended the deceased from <u>5/2/79</u> to <u>Jan 29, 1980</u> , that I (we) last saw the deceased alive on <u>1/29/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.  |  |  |  |   |  |   |  |   |                    |   |  |
| 22b SIGNATURE<br>B.N. ROSENBAUM, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c DATE SIGNED<br>1/30/80  |                    |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>B.N. ROSENBAUM, M.D.   |  |  |  | 22e ADDRESS<br>3720 FARRAGUT AVE<br>KENSINGTON, MD. 20791   |  |   |  |   |                    |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b DATE<br>Feb. 6, 1980  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Colesville Cemetery                      |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Colesville Mont. Md                       |                    |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Tolma Fournier   |  |  |  | ADDRESS<br>251 Canal St NW D  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>FEB 5 1980  |                    | 25b REGISTRAR'S SIGNATURE<br>mrfry/mcbrady  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |
| FIRST MARY  |  |  | MIDDLE F.  |  |  | LAST GIFFORD   |  |  | 1/22/80 12:20 P.M.  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |
| Female  |  |  | Caucasian  |  |  | 4/9/06   |  |  | 13 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Ohio  |  |  | U.S.A.   |  |  | Montgomery   |  |  | MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Silver Spring, Md.  |  |  | Edenhill Villa Nursing Home  |  |  | Gifford's Ice Cream Store  |  |  | owner   |  |  |
| 13a. STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland  |  |  | Montgomery   |  |  | Kensington   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 13e. STREET ADDRESS  |  |  |   |  |  |
| FIRST MIDDLE LAST Thomas White  |  |  | FIRST MIDDLE LAST Anna Woulfe  |  |  | 9615 Bexhill Drive,  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT (son)  |  |  | ADDRESS   |  |  |
| -----   |  |  | 53-01-8418   |  |  | Robert N. Gifford- (same as 13e)   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  |  |  |  |  |  |  |  |   | 3 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Paralysis</u>   |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident</u>  |  |  |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |  |
|   |  |  | P.M. 19  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION  |  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET   |  |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>80</u> to <u>1/22</u> 19 <u>80</u> , that (I) <u>lost</u> saw the deceased alive on <u>1/21/80</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I <u>did</u> <u>not</u> view the body after death.) |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |  |   |  |  |
| <u>A.F. Thibedeau</u>   |  |  | MD   |  |  | 1/22/80  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |
| A.F. Thibedeau, MD  |  |  | 10111 Colesville Rd., Silver Spring, Md.   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |
| Burial  |  |  | 1-24-80  |  |  | Gate of Heaven   |  |  | CITY OR TOWN COUNTY STATE   |  |  |
|   |  |  |  |  |  |  |  |  | Silver Spring Montgomery Md.  |  |  |
| 24. FUNERAL DIRECTOR'S NAME   |  |  | 25a. DATE RECEIVED BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |
| Warner E. Pumphrey, Inc.  |  |  | JAN 28 1980  |  |  | <u>Pumphrey</u>  |  |  |   |  |  |
| 8434 Ga. Ave., S.S. Md.   |  |  |  |  |  |  |  |  |   |  |  |

MEDICAL CERTIFICATION

29

4100



*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 0 0

REG. NO.

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN N. WALTER Gilhool</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-28-80</b> |   |  | 2b. HOUR<br><b>11:20 PM</b>   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fuel Oil</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montg.</b>  |   | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5615 Jordan Rd.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Gilhool</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Finlon</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-09-9012</b>  |   | 17. INFORMANT<br><b>Gerald M. Gilhool</b>   |  | ADDRESS<br><b>22 Pitt Court Rockville, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Coronary Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Th</b> |  |   |   |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Subacute myocardial infarction - obstructive pulmonary disease</b>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/26/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gomene's back</b>  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1/22/80 1980 to 1/28 1980</b>   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/22/80</b> to <b>1/28 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/28</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |   |  |
| 23a. SIGNATURE<br><b>Joseph T. Schanno MD</b>   |  |   |   | DEGREE<br><b>MD</b>   |  | 23b. DATE SIGNED<br><b>1/28/80</b>  |  |   |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph T. Schanno, MD</b>   |  |   |   | 23d. ADDRESS<br><b>2218 Phincross Lane Beth Md</b>  |  |   |  |   |  |
| 23e. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23f. DATE<br><b>Jan. 31, 1980</b>   |   | 23g. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   |  | 23h. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Md.</b>                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Humphrey</b>   |  |   |   | 24b. ADDRESS<br><b>Homes, P.A. Bethesda, Md.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 8002001  |   |
|--|---|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Wilbur C Gilliam Jr.  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 27 80  |  | 2b. HOUR MIN<br>4 10 P M  |   |
| 3 SEX<br>male  | 4 RACE<br>white   | 5 DATE OF BIRTH MONTH DAY YEAR<br>10 8 21  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  | 7 UNDER 1 YEAR MONTHS DAYS<br>7 UNDER 24 HRS. HOURS MIN   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>montgomery County MD.                       |   |   |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Regional Director |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance                              |
| 13a. STATE<br>Md.  |   | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Silver Spring   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>12424 Littleton St.                                  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Wilbur C. Gilliam, Sr.   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary F. Jackson  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO<br>WWII 229-18-4744  |  | 17 INFORMANT ADDRESS<br>Jean N. Gilliam (Same as 13e)   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991<br>DUE TO, OR AS A CONSEQUENCE OF (b) Extensive pericardial metastases<br>DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma, primary unknown |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate 5 MONTHS 8 MONTHS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22 I certify that (I) (the hospital) attended the deceased from July 1st 1977 to Jan 27 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |   |  |  |   |   |
| 22b. SIGNATURE<br>[Signature]  |   | DEGREE   |  | 22c. DATE SIGNED<br>1/28/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LUIS BENTOLILA MD   |   | 22e. ADDRESS<br>5480 Wisconsin Ave. Chevy Chase  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>1-30-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Antioch Baptist Church Cem. Yale Va.                      |   |
| 24 FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey   |   | 24b. ADDRESS<br>Funeral Homes, P.A., Bethesda, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1980  |   |
|  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |

Virginia

Regional Director Lawrence

Jackman

F.

Mr.

William St.

220-15-1750 John H. O'Brien (Name on 13e)

Will

For

BUNIAL

1-30-61

Director, Federal Bureau of Investigation

Chief of the Bureau of Investigation

U.S. Department of Justice

Items #10a-22a Film G541 3/6/80 r5 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 02002

|   |         |   |                   |  |   |   |  |
|---|---------|---|-------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   | MIDDLE            | LAST   | 2a. DATE KNOWN OF DEATH                                       |   | 2b. HOUR                                     |
| JUDITH P. EPER GLEASON  |         |   |                   |  | DATE ESTIMATED  | MONTH DAY YEAR  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD  | 9:28   |
| female  | white   | JUNE 25, 1941   | 38 RS.            | MONTHS DAYS HOURS MIN  |   | 1-14 19 80  | a  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                      |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| WASHINGTON, D. C.   |         | U.S.A.  |                   |  |   | Montgomery County MD.   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION          |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Takoma Pk.  |         | Washington Adventist Hospital                                     |                   |  | HOMEMAKER   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |   |                   | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS   |  |
| 13a. STATE  |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |   |   |  |
| MARYLAND  |         | MONTGOMERY  |                   | SILVER SPRING  |   | 504 DARTMOUTH AVENUE  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |                   |  |   |   |  |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST   |                   |  |   |   |  |
| MILTON C. PEPPER  |         | RUTH E. KNIGHT  |                   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT ADDRESS  |   |   |  |
| NO  |         | 213-38-4214   |                   | JOHN P. GLEASON, JR. SAME AS 13 HUSBAND  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute amitriptyline intoxication</u><br>9503<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |         |   |                   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).   |         |   |                   |  |   |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |                   |  |   | 20. AUTOPSY?  |  |
|   |         |   |                   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>? P.M. 1/14/19 80 |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
|   |         |   |                   | self/ingested  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |                   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |   |  |
|   |         | at home   |                   | 504 Dartmouth Ave. Silver Spring, Montg. MD.   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |  |   |   |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |   |   |  |
| <u>Margarita A. Korell</u>  |         | M.D. Assistant MEDICAL EXAMINER                                   |                   | 1/15/80  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |                   |  |   |   |  |
| Margarita A. Korell, M.D.   |         | 111 Penn Street   |                   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| BURIAL  |         | 1/17/80   |                   | FT. LINCOLN  |   | BRENTWOOD COUNTY MD.  |  |
| 24. FUNERAL DIRECTOR NAME   |         | 25a. DATE REC'D. BY REGISTRAR                                     |                   | 25b. REGISTRAR'S SIGNATURE   |   |   |  |
| FRANCIS J. COLLINS  |         | JAN 16 1980   |                   | <u>Francis J. Collins</u>  |   |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |         |   |                   |  |   |   |  |





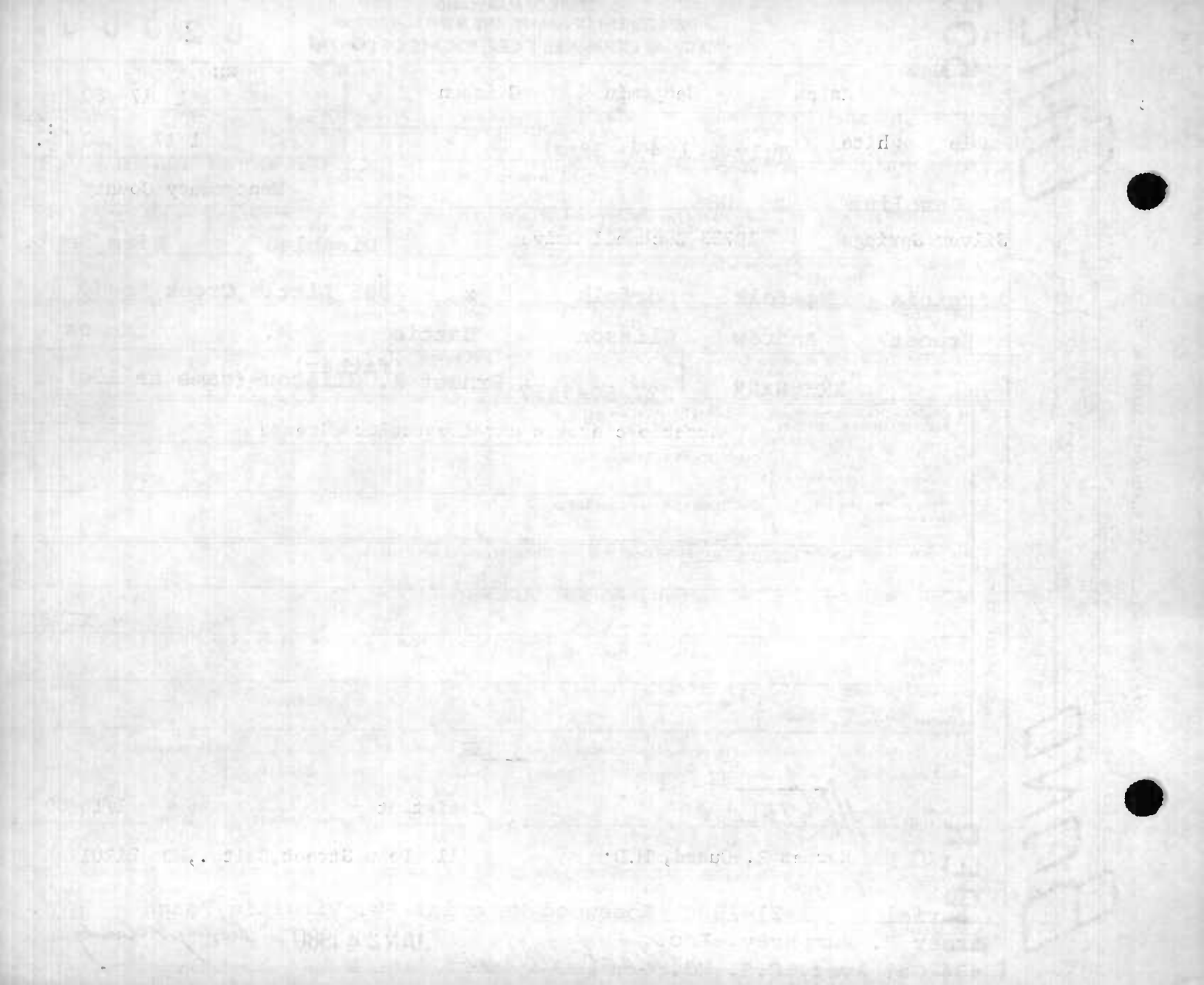
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                                |  |  |  |  |  |  |   |  | REG. NO. 02003                               |  |
|--|--------------------------------|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ralph Benjamin Glisson</b>  |                                |  |  |  |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1 17 1980</b> |  | 2b. HOUR <b>AM</b>  |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8 1940</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>39 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 17 1980</b>   |  | 7d. HOUR<br><b>8:27 PM</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Montgomery County</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Springs</b>   |                                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)<br><b>10723 Bucknell Drive</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fire Dept.</b>                              |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                |  |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Virginia</b>  | 13b. COUNTY<br><b>Noe folk</b> | 13c. CITY OR TOWN<br><b>Norfolk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>555 Little Creek Road,</b>   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Andrew Glisson</b>   |                                |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie M. Thames</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>  |                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>XXXXXX</b>   |  | 17. INFORMANT (father) ADDRESS<br><b>Ernest A. Glisson-(same as 13e)</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                                |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                                |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |                                |  |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b>   |                                |  |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |  |  | DATE SIGNED <b>1/18/80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |                                |  |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                                | 23b. DATE<br><b>1-21-1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosewood Memorial Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia Beach Va.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |                                |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Clark E. W...</b>   |  |   |  |  |  |
| 26. ADDRESS<br><b>8434 Ga. Ave., S.S. Md.</b>  |                                |  |  |  |  |  |  |   |  |  |  |

BP

DHMH - 17  
(19R A15 ME (5))  
15M 7/76





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as such, it shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8002004   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |  |  |
| Herman Goldberg  |  |  |  | January 1, 1980   |  | 10:30A  |  | M  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR  |  |
| Male   |  | White  |  | 1904<br>July 7, 1904  |  | 75  |  | MONTHS DAYS HOURS MIN                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| New York   |  | USA  |  |   |  | Montgomery  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Silver Spring  |  | Holy Cross Hospital  |  | Foreman   |  | Textile Factory   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Md.  |  | Prince Geo.  |  | Beltsville  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 11220 Evans Trail 103                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                                      |  |
| Isaac ----- Goldberg   |  | Sarah ----- Silverman  |  | No  |  | 171-03-9066   |  | Maryland<br>Jerome Goldberg, 13808 Overlook, Silver Spring |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| 1991   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | Cardiac arrest  |  | 20 mins   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | progressive respiratory failure   |  | 3 mos   |  |  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | Malignant mesothelioma  |  | 1 yr  |  |  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (the deceased) attended the deceased from <u>Feb</u> 19 <u>79</u> to <u>Jan</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Dec</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>examine</u> the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |  |  |
| Kirk F. Feury  |  |  |  |   |  | 1/1/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |
| KIRK F FEURY   |  | 9410 Old Georgetown  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial   |  | 1-3-79   |  | King David Mem. Gdn.  |  | Falls Church, Virginia  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| DANZANSKY-GOLDBERG MEM. CHAP.  |  | Rockville, Md.   |  | JAN 1 1980  |  | [Signature]   |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0002005

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |                                       |   |  |                 |   |          |
|---|---|--|--|--|---------------------------------------|---|--|-----------------|---|----------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST  | MIDDLE   | LAST   | 2a. DATE OF DEATH                     |   | MONTH  | DAY             | YEAR  | 2b. HOUR |
| Norman  |   |  |  | Goldberg   | 1                                     |   | 20   | 80              |   | 7:57AM   |
| 3 SEX   | 4 RACE  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |                                       | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS |   |          |
| MAL   | WHITE   | MONTH DAY YEAR<br>3-30-1916  |  | 63   |                                       | MONTHS DAYS   |  | HOURS MIN       |   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                                       |   |  |                 |   |          |
| Pennsylvania  | USA   |  |  | Montgomery   |                                       |   |  |                 |   |          |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY     |   |  |                 |   |          |
| Olney   | Mont. Gen. Hospital   |  | Retailer   |  | Liquor Store                          |   |  |                 |   |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |  |  |  | 13d. INSIDE CITY LIMITS?              |   | 13e. STREET ADDRESS  |                 |   |          |
| 13a. STATE<br>MARYLAND  |   |  |  |  | 13b. COUNTY<br>Prince George          |   | 13c. CITY OR TOWN<br>MATTESVILLE                           |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |
| 14 FATHER'S NAME  |   |  |  |  | 15. MOTHER'S MAIDEN NAME              |   |  |                 |   |          |
| FIRST MIDDLE LAST<br>Louis Goldberg   |   |  |  |  | FIRST MIDDLE LAST<br>Esther (unknown) |   |  |                 |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |  |  |  | 16b. SOCIAL SECURITY NO.              |   | 17 INFORMANT ADDRESS                                       |                 |   |          |
| No  |   |  |  |  | 196-01-0112                           |   | Silver Spring, Md.<br>Edward Goldberg; 13708 Lockdale Rd., |                 |   |          |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br><u>4149</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 HOURS</u><br><u>5 YEARS</u> |   |  |  |  |                                       |   |  |                 |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CONGESTIVE HEART FAILURE ; DIABETES</u>  |   |  |  |  |                                       |   |  |                 |   |          |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                        |  |                 |   |          |
| NONE  |   | N/A  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       | YES <input type="checkbox"/> N/A <input type="checkbox"/> NO <input type="checkbox"/> |  |                 |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. N/A 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N/A  |                                       |   |  |                 |   |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |                                       | CITY OR TOWN  |  | COUNTY STATE    |   |          |
|   |   |  |  |  |                                       |   |  |                 |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>80</u> , to <u>1/20</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (each) did not view the body after death.   |   |  |  |  |                                       |   |  |                 |   |          |
| 22b. SIGNATURE<br><u>Alan N. Schulman, MD</u>   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       | 22c. DATE SIGNED<br><u>1/20/80</u>  |  |                 |   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ALAN N. SCHULMAN</u>  |   |  |  | 22e. ADDRESS<br><u>19271 MONTGOMERY VILLAGE AVE; MD 20760</u>  |                                       |   |  |                 |   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                       | 23d. LOCATION<br>CITY OR TOWN   |  |                 |   |          |
| Burial  |   | 1-21-1980  |  | Nat'l. Memorial Park   |                                       | Falls Church, Fairfax, Va.  |  |                 |   |          |
| 24. FUNERAL DIRECTOR<br>NAME  |   | 1170 Rockville Pike, Rockville, Md.  |  | 24b. DATE REC'D BY   |                                       | JAN 25 1980   |  |                 |   |          |
| DANEANSKY   |   | 6600 RG  |  | ROCKVILLE, MD  |                                       |   |  |                 |   |          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

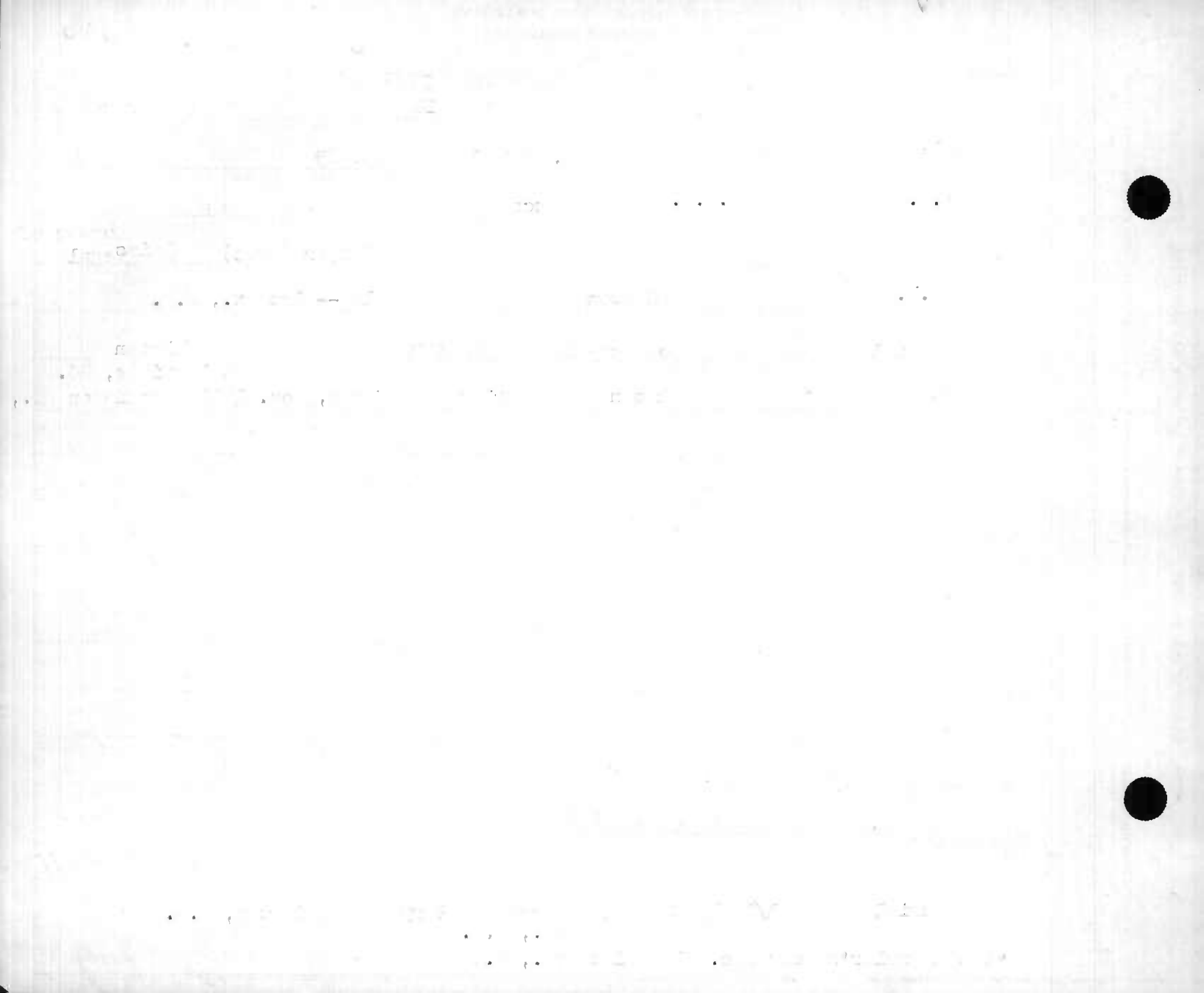
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | 700 02006<br>REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>DANIEL</u> MIDDLE <u>M</u> LAST <u>GOODACRE II</u><br><u>DANIEL M GOODACRE II</u>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>1-15-80</u> 2b. HOUR<br><u>6:30 AM</u> |  |  |  |  |
| 3 SEX<br><u>Male</u>   |  | 4 RACE<br><u>White</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>Mar. 14 1896</u>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>83</u> YRS.                                     |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>D.C.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                         |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Silver Spring</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Holy Cross Hospital</u>              |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Lawyer (Ret)</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Bureau of Claims</u> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>D.C.</u> 13b. COUNTY <u>Washington</u>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><u>6156--31st St., N.W.</u>   |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Daniel M Goodacre I</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Unknown Unknown</u>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>Yes</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>Unknown</u>  |  | 17. INFORMANT ADDRESS<br><u>Charles R Goodacre, Son, 17125 Hoskinson Rd., Poolesville, Md.</u>   |   |  |  |  |  |
| II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).<br><u>4392</u> <u>Cardiac-Respiratory Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><u>Due to, or as a consequence of, Acute and Chronic Congestive Heart Failure year</u><br><u>Due to, or as a consequence of, Atherosclerotic Coronary Arteriosclerosis year</u> |  |   |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).   |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>January 14, 1980</u> to <u>Jan 15, 1980</u> , that (1) (we) lost saw the deceased alive on above (1) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Benjamin H. Aronson, M.D.</u>   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  |  | 22c. DATE SIGNED<br><u>1-15-80</u>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Benjamin H. Aronson, M.D.</u>  |  | 22e. ADDRESS<br><u>3720 Farnsworth Ave. Ken, Md. 20715</u>  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>1/18/1980</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Washington, D.C.</u>                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Joseph Gawler's Sons Inc.</u>  |  | ADDRESS<br><u>5130 Wisc Ave., N.W.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 21 1980</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McCready</u>                                |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                  |  |  |  |
|--|--|--|--|--|--|---|--|----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. REG. NO.  |  | 8 0 0 2 0 0 1  |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                                     |  |
| IRVING   |  | GORDON   |  |  |  |   |  | 1-26-80                          |  | 9:25 PM                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS      |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| MALE   |  | Cauc   |  | 2 15 01  |  | 78  |  | YRS.                             |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                  |  |  |  |
| RUSSIA   |  | United STATES  |  |  |  | MONTGOMERY MD.  |  |                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                  |  |  |  |
| BETHESDA   |  | Suburban   |  | GROCER   |  | OWN BUSINESS  |  |                                  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS              |  |  |  |
| MARYLAND   |  | MONTGOMERY   |  | SILVER SPRING  |  |   |  | 8750 GEORGIA AVE., APT. 602B     |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                  |  |  |  |
| HYMAN  |  | GORDON   |  | SARA   |  | ELSBERG   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                  |  |  |  |
| NO   |  | 578-03-4450  |  | JERRY GORDON   |  | 10710 EASTWOOD AVE., SIL. SPR., MD  |  |                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 RESPIRATORY FAILURE  |  |  |  |  |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA   |  |  |  |  |  |   |  |                                  |  | 2 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMATOSIS TERMINAL   |  |  |  |  |  |   |  |                                  |  | 3 years                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |  |
| 1-14-80  |  | INTESTINAL OBSTRUCTION   |  |  |  |   |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                  |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY                           |  | STATE  |  |
|  |  |  |  |  |  |   |  |                                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-27, 1979, to 1-26, 1980, that (I) (we) last saw the deceased alive on 1-26, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                                  |  |  |  |
|  |  |  |  |  |  | 1-27-80   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |  |  |
| BERNY J. KREUTZ  |  | 5411 CEDAR LN BETH. MD.  |  |  |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                  |  |  |  |
| BURIAL   |  | JAN. 29, 1980  |  | KING DAVID MEM. GARDEN   |  | FALLS CHURCH, FAIRFAX, VIRGINIA   |  |                                  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |  |  |
| DANZANSKY-GOLDBERG   |  | MEMORIAL CHAPELS, ROCKVILLE, MD.   |  | FEB 5 1980   |  | Crosby  |  |                                  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |   |  |   | REG. NO. 002008  |  |  |  |          |  |
|--|--|--|---|--|--|---|---|--|---|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |   |   |  |   | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Donald Andrew Graham, Sr.</b>  |  |  |   |  |  |   |   |  |   | MONTH DAY YEAR<br><b>01 17 80</b>  |  | HOURS MIN.<br><b>2:00AM</b>                              |  |          |  |
| 3 SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>white</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar 16 1919</b>  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b>  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b> |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                       |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery Gen. Hosp.</b> |  |  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Iron</b> |  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY OR TOWN 13c. CITY OR TOWN<br><b>Maryland Montgomery Rockville</b>  |  |  |   |  |  |   |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>13021 Evanston Street</b>      |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Graham</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Sylves</b>            |   |   |  |   |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE AR OR DATES)<br><b>WA 11 190 03 9652</b> |   | 17. INFORMANT ADDRESS<br><b>Donald A. Graham 19305 Clubhouse Rd. #301 Gaithersburg, Md. 20760</b> |  |   |  |  |  |  |          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>shock, irreversible</b><br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>severe coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>42 hours</b><br><b>42 hours</b><br><b>years</b> |  |  |   |  |  |   |   |  |   |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |   |   |  |   |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>80</b> , to <b>1/17</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)  |  |  |   |  |  |   |   |  |   |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Mark S. Rosen MD</b>  |  |  |   | DEGREE   |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/17/80</b>   |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark S. Rosen MD</b>   |  |  |   | 22e. ADDRESS<br><b>Silver Spring, Md.</b>                              |  |   |   |  |   |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  |   | 23b. DATE<br><b>1/18/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>           |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852</b>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                               |  |  |  |  |          |  |

MEDICAL CERTIFICATION

3301 BP

1919

Andrew G. G. G.

1919

x

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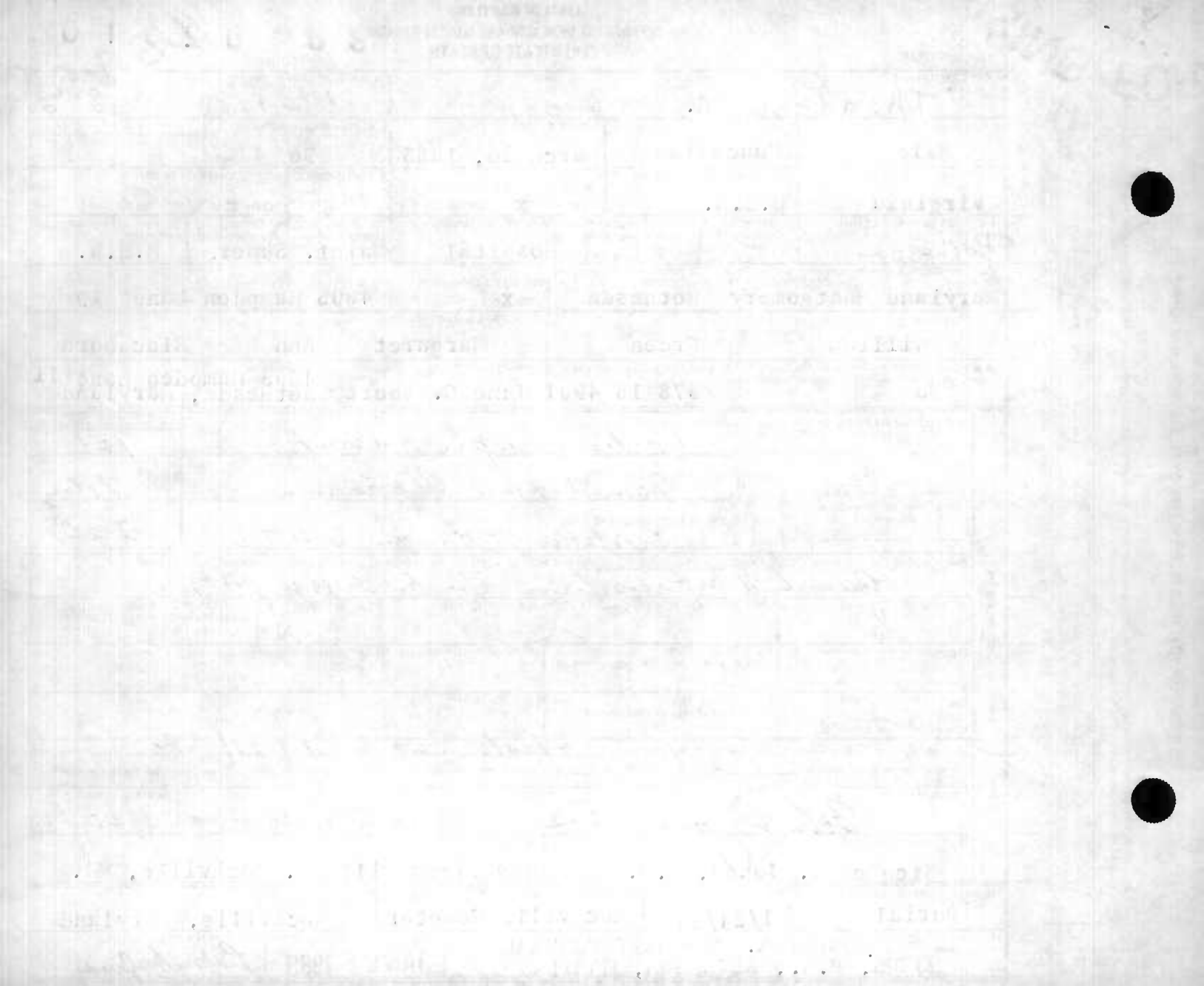


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |   |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <u>Thaddeus C. Green</u>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>1/21/80</u>   |  | 2b. HOUR<br><u>8:30</u> P.M.                       |  |  |
| 3 SEX<br><u>Male</u>   |  | 4 RACE<br><u>Caucasian</u>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><u>March 26, 1883</u>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>96</u> YRS  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><u>96</u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery Co.</u> MD.                         |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Bethesda</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Suburban Hospital</u> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Maint. Super.</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>H.E.W.</u>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Maryland</u> 13b. CITY OR TOWN <u>Montgomery</u> 13c. CITY OR TOWN <u>Bethesda</u>  |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>4805 Hampden Lane #9</u> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William Green</u>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Margaret Ann Blackburn</u>                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>578 18 4901</u>   |  | 17 INFORMANT<br>ADDRESS<br><u>June G. Abert 4805 Hampden Lane #11 Bethesda, Maryland</u>   |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio - respiration arrest</u><br>600-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>from negative Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Prostatic obstruction &amp; U.T.I.</u> |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15'</u><br><u>7 days</u><br><u>2 wks</u>                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Generalized arteriosclerosis, Fractured Hip (post)</u>  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>1/21/80</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Fractured Hip</u>  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/80</u> to <u>1/21/80</u> , that (I) (we) last saw the deceased alive on <u>1/21/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Stephen N. Jones</u>  |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br><u>1/22/80</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stephen N. Jones, M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>809 Viers Mill Rd. Rockville, Md.</u>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>1/24/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rockville Cemetery</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Rockville, Maryland</u>                 |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br><u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</u>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 28 1980</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Pumphrey</u>                                  |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 1 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred Witcraft Greenlaw  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 20, 1980                |   |  | 2b. HOUR<br>11:10 <sub>M</sub>   |  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 18, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Oklahoma   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Carriage Hill-Bethesda Cedar Ia. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery  |   |  | 13c. CITY OR TOWN<br>Chevy Chase   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(unavailable) Witcraft  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unavailable           |   |  | 13e. STREET ADDRESS<br>6909 Strathmore Street  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>578-40-7394A                               |   |  | 17. INFORMANT<br>ADDRESS<br>3607 Coolidge Ave.<br>Mary M. Starin, Oakland, Calif.  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>4919<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Bronchitis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>2 years.   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Familial Tremor   |  |   |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December 29, 1980, to 20 January 1980, that (I) (we) lost saw the deceased alive on 17 January 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Harold I. Passes M.D.   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>20 January 1980  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAROLD I. PASSES M.D.  |  |   | 22e. ADDRESS<br>4425 Montgomery Ave Bethesda Md 20014                  |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |   | 23b. DATE<br>1-22-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland   |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 28 1980  |  |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8002012  |  |                      |  |
|---|--|---|--|---|--|--|--|---|--|---|--|----------------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <i>Jesse</i>   |  |   |  | FIRST <i>Gregory</i>   |  | LAST  |  | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>15</i> YEAR <i>80</i> |  | 2b. HOUR <i>80</i> M |  |
| 3 SEX <i>Male</i>   |  | 4 RACE <i>B</i>   |  | 5 DATE OF BIRTH MONTH <i>2</i> DAY <i>8</i> YEAR <i>05</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.  |  | 7 IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>   |  | 8 IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>                 |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tennessee</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.   |  |   |  |   |  |                      |  |
| 10 CITY OR TOWN OF DEATH <i>Bethesda</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Postal Transport</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>   |  |   |  |                      |  |
| 13a. STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Montgomery</i>   |  | 13c. CITY OR TOWN <i>Bethesda</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <i>7505 Democracy Blvd.</i>   |  |   |  |                      |  |
| 14 FATHER'S NAME FIRST <i>Spencer</i> MIDDLE <i></i> LAST <i>Gregory</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Winnie</i> MIDDLE <i></i> LAST <i>Barry</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  |  |  | 16b. SOCIAL SECURITY NO. <i>579-14-5412</i>   |  | 17 INFORMANT ADDRESS <i>Mary E.C. Gregory, Wife</i> SAA       |  |                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Renal Failure</i><br><i>5849</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i> |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Abdominal Aortic Secondary to extraabdominal malignancy</i>   |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <i></i> AT WORK <i></i>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>October 74</i> 19 <i>74</i> to <i>January 15</i> 19 <i>80</i> , that (I) (we) lost <i>now the deceased alive on above</i> 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| 22b. SIGNATURE <i>J. Blaine Fitzgerald</i> DEGREE <i>MD</i>   |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <i>1-15-80</i>   |  |   |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Blaine Fitzgerald</i>   |  |   |  |   |  | 22e. ADDRESS <i>8600 Old Georgetown Road Beth., Md.</i>  |  |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>1/18/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Crown Hill Cem.</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Indianapolis, Indiana</i>   |  |   |  |   |  |                      |  |
| 24 FUNERAL DIRECTOR NAME <i>McGuire Funeral Service</i>   |  | ADDRESS <i>Washington, DC</i>   |  | 25a. DATE READ BY REGISTRAR <i>JAN 21 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>John McCrady</i>   |  |   |  |   |  |                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8002013  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Doris Sheldon Grieb   |  |  |  | 2b. HOUR<br>4 <sup>50</sup> P.M.  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 8, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>77 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>25 Eton Overlook |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Computer Operator  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br>Maryland Montgomery Rockville  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>25 Eton Overlook   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Leonard Sheldon  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Not available Allen   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>579-48-6074  |  | 17. INFORMANT ADDRESS<br>Johannah Holman, Same as 13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br>19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/5</u> , 19 <u>77</u> , to <u>12/25</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Stephen J. Newman</u>   |  |  |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>12/26/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen J. Newman, MD.   |  |  |  | 22e. ADDRESS<br>5411 Cedar Lane #203 Bethesda Maryland  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>1/27/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Alexandria, Va.  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Mickey McCready   |  |

RECEIVED  
JAN 1 1911  
DEPT. OF CORRECTIONS  
LANSING, MICH.  
FROM THE  
SHERIFF OF THE  
COUNTY OF  
JAN 1 1911

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

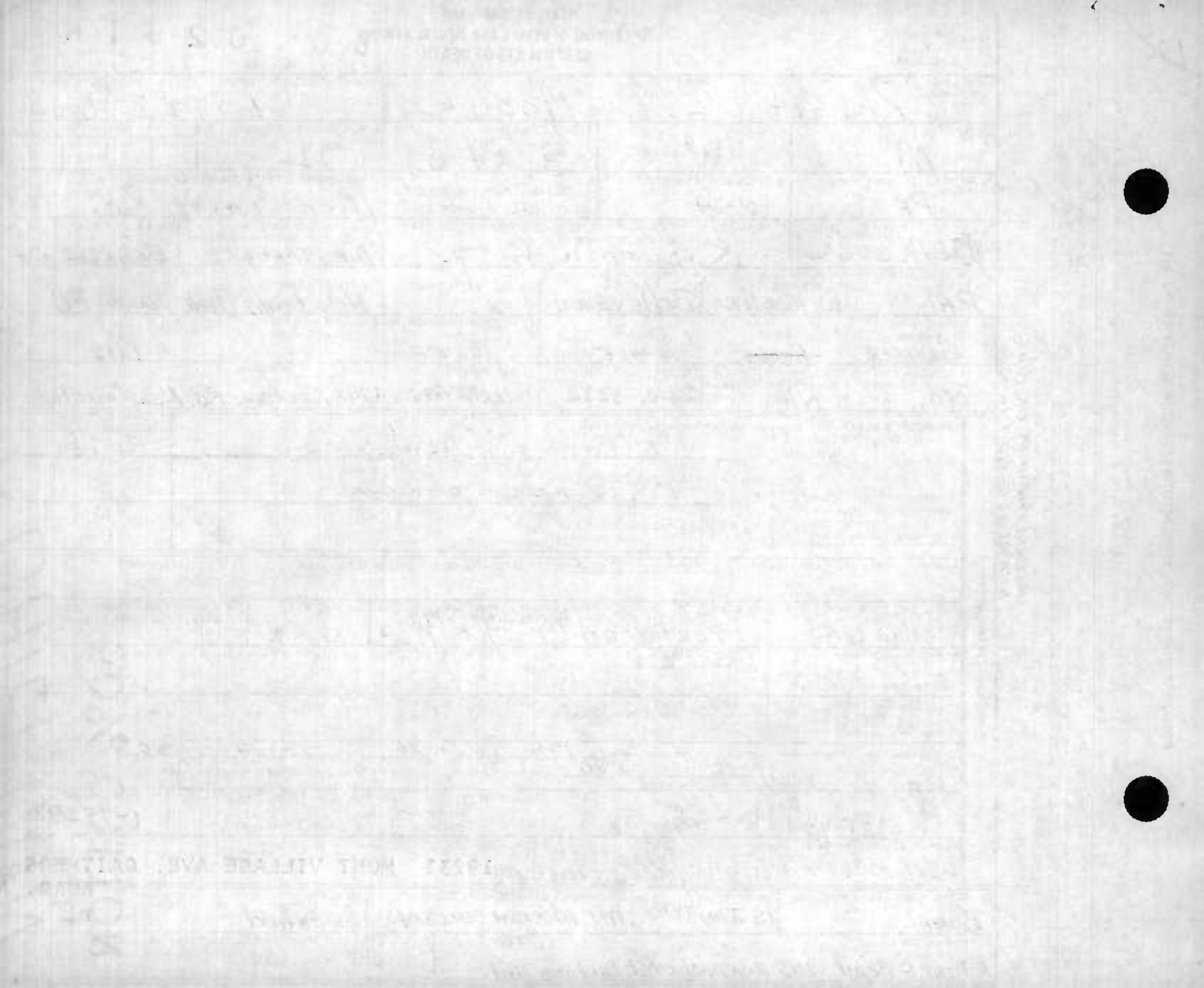
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL EXAMINER DR. BALL  
NOTIFIED + CLEARED 1-12-80

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. 8002014                                       |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert G. Hague  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 80  |  | 2b. HOUR 6:00 AM                                       |  |  |  |
| 3 SEX M   |  | 4 RACE W  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3 24 07  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.                                      |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTANENCE                    |  | 12b. KIND OF BUSINESS OR INDUSTRY ENGINEERING   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA  |  | 13b. COUNTY W. MORTEN   |  | 13c. CITY OR TOWN BELLE VERNON   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS Holy Farms Belle Vernon Rd  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST SNYDER HAGUE HAGUE  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA - Di's   |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. N/A  |  | 208-01-8282  |  | 17. INFORMANT ADDRESS ROBERTA FREW 7748 RIVERDALE Rd, NEW CARROLLTON                         |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 410 - Coronary Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (?) 1 hr. |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION 1/10/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured right hip  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-9 1980, to 1-12 1980, that (I) (we) lost saw the deceased alive on 1-12 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE Loren Z. Marcoun MD  |  |   |  | DEGREE MD COVERING ORTHO. SURGERY  |  |  |  | 22c. DATE SIGNED 1-12-80  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOREN Z. MARCOUN MD / MARSHAL ACKERMAN MD   |  |   |  | 22e. ADDRESS 19231 MONT VILLAGE AVE, GAITHERS-BURG, PA.  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 15 JAN 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY MT. MIRARA CEMETERY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Smithfield PA.                                       |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ROBERT G BEALL  |  |   |  | ADDRESS 9013 ANNAPOLIS Rd. LANTHAM Md.   |  | 25a. DATE REC'D BY REGISTRAR JAN 22 1980   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 1 5

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET C HALDEMAN</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01- 06 80</b>   |  | 2b. HOUR<br><b>11:30P M</b>  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12-27-02</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>OLNEY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MONTGOMERY GENERAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INSPECTOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WESTINGHOUSE</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>   |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES J. RIEGER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOUISE MARY HASLAGE</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>188-18-4556</b>   |  | 17. INFORMANT<br><b>DAUGHTER</b> ADDRESS<br><b>8517 EDENTON CT.</b>  |  | 17. INFORMANT<br><b>MARGARET A. ADOLPHSEN</b> ADDRESS<br><b>FULTON, MD. 20759</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastases</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Repeated Abdominal abscesses</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>due to ruptured colon diverticulae</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years 2 m</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Uremia secondary to sepsis, obstructive uropathy and hepatic sclerosis</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1976</b> to <b>6 Jan</b> , 19 <b>80</b> , that (I) <del>was</del> last saw the deceased alive on <b>6 January</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gustavo S. Belaval, MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7 Jan 80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gustavo S. Belaval</b>  |  |   |  | 22e. ADDRESS<br><b>Leisure world Medical Center Silver Spring, Md 20906</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>1/8/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VIRGINIA</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR<br><b>JAN 9 1980</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | 8002016                      |  |  |  |                                     |  |          |  |
|--|--|---|--|--|--|--|--|---|--|------------------------------|--|--|--|-------------------------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH                         |  | MONTH                        |  | DAY  |  | YEAR                                |  | 2b. HOUR |  |
| FRANK  |  | W.  |  | HALL   |  |  |  | January                                   |  | 27,                          |  | 1980   |  |                                     |  | M        |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |          |  |
| Male   |  | Black   |  | Feb. 3, 1939   |  | 40   |  | Md.                                       |  | U.S.A.                       |  |  |  | MONTGOMERY                          |  | MD.      |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |                              |  |  |  |                                     |  |          |  |
| Takoma Park  |  | Washington Adventist Hospital   |  | Truck Driver   |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                  |  | 13e. STREET ADDRESS          |  |  |  |                                     |  |          |  |
| Md.  |  | Montg.  |  | Takoma Park  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 103 Sheridan Ave.                         |  |                              |  |  |  |                                     |  |          |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| Charles N. Hall  |  | Margie V. Hammond   |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  | ADDRESS  |  |   |  |                              |  |  |  |                                     |  |          |  |
| Yes  |  | 217-32-2770   |  | Margie Hall (Mother)   |  | 10707 Shaftsbury St<br>Kensington, Md. 20795                   |  |   |  |                              |  |  |  |                                     |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) _____<br>2028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |                              |  |  |  |                                     |  |          |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |                              |  |  |  |                                     |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| 21d. INJURY OCCURRED.<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY                                    |  | STATE                        |  |  |  |                                     |  |          |  |
|  |  |   |  |  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| 22a. I certify that (for this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased pass on below. (If we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. ADDRESS   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)     |  | 22e. DATE SIGNED             |  |  |  |                                     |  |          |  |
|  |  |   |  |  |  |  |  | Lewis H. Dennis, M.D.                     |  | JAN 3 1 1980                 |  |  |  |                                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                  |  | COUNTY                                    |  | STATE                        |  |  |  |                                     |  |          |  |
| Burial   |  | 2-1-80  |  | Ebenezer Cemetery  |  | Centerville,   |  | Md.                                       |  |                              |  |  |  |                                     |  |          |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  | 24b. DATE REC'D. BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE   |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |
| George R. Snowden  |  | JAN 3 1 1980  |  | Mary McCreedy  |  |  |  |   |  |                              |  |  |  |                                     |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 1 7

| FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |
|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert Byng Hall</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 08 80</b>   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 13 04</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AUTO BUSINESS</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  |
| 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ORLANDO G. HALL</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESTHER V. BYNG</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-03-3602</b>  |  |
| 17 INFORMANT<br><b>MILDRED I. HALL, WIFE</b>  |  | ADDRESS<br><b>SAME AS 13</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 h</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 70</b> to <b>8 Jan</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8 Jan</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |
| 22b. SIGNATURE<br><b>William Aud MD</b>   |  | 22c. DATE SIGNED<br><b>1/9/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM AUD</b>   |  | 22e. ADDRESS<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/11/80</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND PRI GEO MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1980</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  | 25c. ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD., 20901</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the effective management of any business or organization. This section also outlines the various methods and tools that can be used to ensure the accuracy and reliability of the data collected.

2. The second part of the document focuses on the role of technology in modern record-keeping. It explores how digital tools and software can streamline the process of data collection, storage, and analysis. This section also discusses the challenges associated with using technology, such as data security and privacy concerns, and offers strategies to address these issues.

3. The third part of the document provides a detailed overview of the legal requirements for record-keeping. It covers the various regulations and standards that must be followed to ensure compliance with the law. This section also discusses the consequences of non-compliance and offers guidance on how to avoid legal pitfalls.

4. The fourth part of the document discusses the importance of regular audits and reviews of the record-keeping system. It emphasizes that periodic audits are necessary to identify any errors or discrepancies in the data and to ensure that the system is up-to-date and accurate. This section also outlines the steps involved in conducting a thorough audit and offers tips for improving the overall quality of the record-keeping process.

5. The fifth and final part of the document provides a summary of the key points discussed in the previous sections. It reiterates the importance of accurate record-keeping and offers final thoughts on the role of technology, legal requirements, and regular audits in ensuring the effectiveness of the record-keeping system.

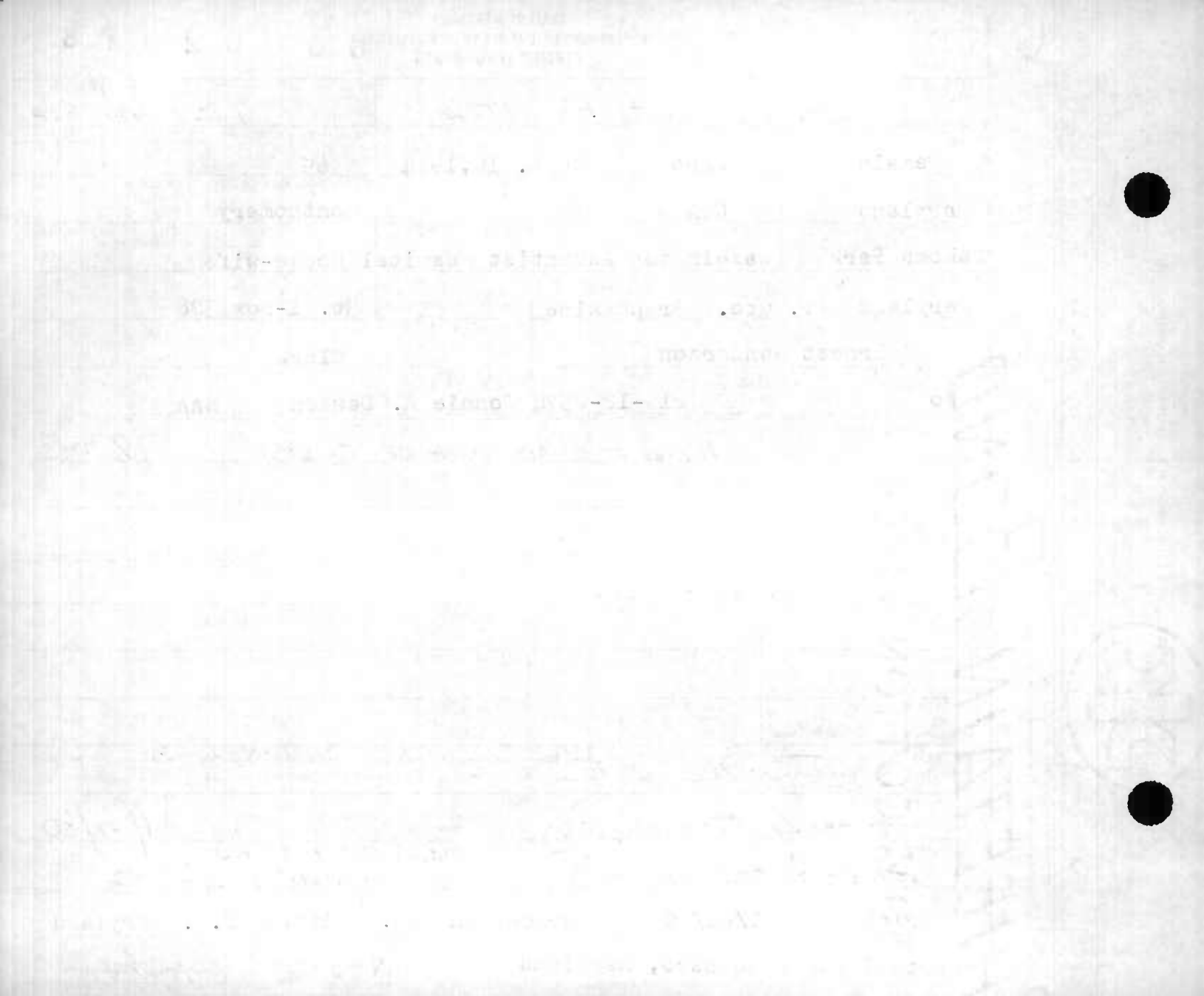


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8002013   |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Ernestine Modesta Hamilton</i>  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR <i>1 21 1980</i>             |  |  | 2b HOUR <i>8 AM</i>  |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>Negro</i>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sept. 14, 1914</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>65</i> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                         |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Takoma Park</i>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>House-wife</i> |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <i>Maryland</i> 13b CITY OR TOWN <i>Pr. Geo. Brandywine</i> 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 13e STREET ADDRESS<br><i>Rt. 1-Box 378</i>                   |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ernest Henderson</i>  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Clark</i> |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b SOCIAL SECURITY NO.<br><i>219-12-2574</i>  |  | 17 INFORMANT<br>ADDRESS<br><i>Connie M. Dawson SAA</i>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA OF BREAST</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>18 mos</i> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>DIABETES MELLITUS</i>  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>JULY 1978</i> to <i>JANUARY 20, 1980</i> , that (we) lost<br>saw the deceased alive on <i>JANUARY 20, 1980</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (we) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>James A. Brown, MD</i>   |  |  |  | DEGREE<br><i>MD</i>  |  |  |  | 22c. DATE SIGNED<br><i>1/21/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES A. BROWN, MD</i>  |  |  |  | 22e. ADDRESS<br><i>655 BACREST RD<br/>HYATTSVILLE MD 20782</i>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1/24/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resurrection Cem.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Clinton P.G. Maryland</i>           |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Martell Adams Aquasco, Maryland</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 29 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Kennedy</i>                                |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8002019   |  |   |   |
|--|--|--|--|--|--|---|---|
| 1- FOR STATE REGISTRAR   |  |  |  | 2a DATE OF DEATH   |  |   |   |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>DOROTHY MAE HANLON  |  |  |  | MONTH DAY YEAR<br>1 16 80  |  | 2b HOUR<br>11:30 P.M.   |   |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>JAN 21, 1918   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D. C.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |   |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10721 MEADOWHILL ROAD |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADM. OFFICE  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>C.A.B.  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a INSIDE CITY LIMITS?  |  |   |   |
| 13a STATE<br>MARYLAND  |  | 13b COUNTY<br>WORCHESTER   |  | 13c CITY OR TOWN<br>OCEAN CITY   |  | 13d STREET ADDRESS<br>714 TWIN TREE ROAD  |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JOSEPH H. GIEBEL, SR.  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>VERNELL H. REYNOLDS   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>577-14-1184  |  | 17 INFORMANT ADDRESS<br>D. JOSEPH HANLON SAME AS 13 HUSBAND  |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic brain disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Bronchogenic ca</u>  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Days</u><br><u>2 yrs</u><br><u>2 yrs</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>16 JAN</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>16 JAN</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |
| 22b SIGNATURE<br><u>Robert T. Kelley</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c DATE SIGNED<br>17 Jan 80  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT T. KELLEY   |  | 22e ADDRESS<br>8218 WISCONSIN AVE BETHESDA, MD 20814   |  |  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>1/19/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.   |   |
| 24 FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS   |  | 24b ADDRESS<br>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 22 1980  |  | 25b REGISTRAR'S SIGNATURE<br><u>Robert T. Kelley</u>  |   |

BP

200 LUTY BLVD. N. SILVER SPRING MD. 20901  
 FRANCIS J. COLLINS  
 1/17/80 DATE OF DEATH  
 SILVER SPRING MD.

577-1-1184 P. JOSEPH WATSON  
 SAME AS 13 HUSBAND

JOSEPH WATSON  
 41  
 100 WEST 28  
 VERMONT  
 H. REYNOLDS

CARLAND MONCHESTER OCEAN CITY  
 1001 TWIN TREE ROAD  
 ADV. OFFICE  
 C.A.B.  
 MONTGOMERY  
 WHITE  
 JAN 21 1978  
 41

DOBSON  
 WAF  
 WATSON

Case closed with medical examiner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

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Dr. John R. Rogers

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |   |  |  |
|---|--|--|--|--|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO. 002020   |   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: Grace, MIDDLE: S., LAST: Hannauer  |  |  |  |  | 2a. DATE OF DEATH MONTH: January, DAY: 25, YEAR: 1980   |   |   |   |  |  |
| 3. SEX: F   |  | 4. RACE: W   |  | 5. DATE OF BIRTH MONTH: Sept, DAY: 12, YEAR: 1894  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.   |   | 7b. HOUR: 5 <sup>00</sup> P. M.               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH: Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carriage Hill Nursing Home |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY:            |  |  |
| 13a. STATE: Maryland  |  |  |  |  | 13b. CITY OR TOWN: Silver Spring  |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS: 811 Thayer Avenue |  |
| 14. FATHER'S NAME FIRST: Benjamin, MIDDLE: , LAST: Smith  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST: Not available, MIDDLE: , LAST:  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No   |  | 16b. SOCIAL SECURITY NO.: 214-12-7580-B  |  | 17. INFORMANT: Hazel A. Rickard (sister), ADDRESS: 53-1st Avenue, St. Louis, Mo.   |   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): Pneumonia<br>486-<br>DUE TO, OR AS A CONSEQUENCE OF (b):<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Several days |  |  |  |  |   |   |   |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Generalized arteriosclerosis - cerebrovascular accident with (R) hemiparesis  |  |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION: None recent   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: -  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):  |   |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE:  |   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975, 19, to January 25, 1980, that (I) (we) last saw the deceased alive on January 25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE: Bennet A. Porter, Jr., M.D.   |  |  |  |  | DEGREE: M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED: January 25, 80              |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Bennet A. Porter, Jr., M.D.  |  |  |  |  | 22e. ADDRESS: 9301 Coleridge Rd., Silver Spring, Md., 20901   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial   |  | 23b. DATE: Jan 25-1980   |  | 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln  |   | 23d. LOCATION CITY OR TOWN: Bethesda, Md. COUNTY: P. Hoo. STATE: Md.  |   | 23e. DATE REC'D. BY REGISTRAR: 25 JAN 30 1980 |  |  |
| 24. FUNERAL DIRECTOR: William H. Hall   |  |  |  |  | 25. REGISTRAR'S SIGNATURE: P. Hoo. Hall   |   |   |   |  |  |



TO THE DIRECTOR, U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   | REG. NO. 8002021  |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Edward J. HANNON, Jr.  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 2 1980                    |  |   |  | 2b. HOUR<br>8:49P <sup>M</sup>               |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 11 1920  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Navy          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Virginia   |  | 13b. COUNTY<br>Fairfax  |   | 13c. CITY OR TOWN<br>Vienna   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>108 Harmony Drive S. E.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edward J. Hannon Sr.  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie Katherine McKenna |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO<br>1943-63  |   | 17. INFORMANT ADDRESS<br>Mrs. Terry Carlisle 3828 Dare Circle Norfolk, Va.  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Carcinoma of the lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December 12, 1979, to January 2, 1980, that (I) (we) last saw the deceased alive on January 2, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br>James K. O'Donnell   |  |   |   |   | DEGREE<br>MD  |  |   | 22c. DATE SIGNED<br>Jan. 3 1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James K. O'Donnell, M.D.  |  |   |   |   | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.          |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Jan. 4, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Va. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Money & King Funeral Home Vienna, Va.  |  |   |   |   | 25. JAN 9 1980 BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                |  |   |  |  |



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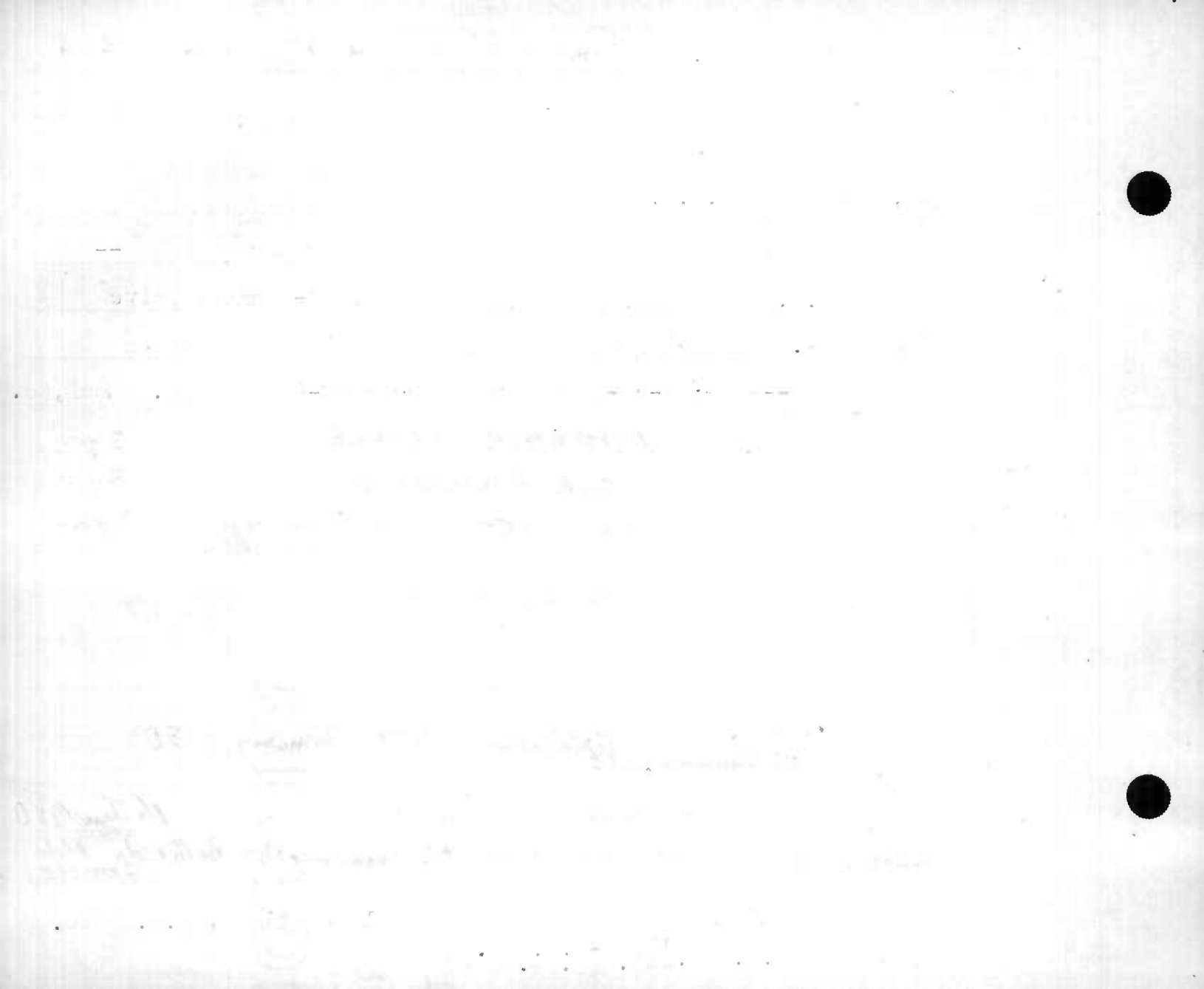


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                            |  | REG. NO. 8002022              |  |  |  |
|--|--|--|--|---|--|--|--|----------------------------|--|-------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | Mary B. Hare   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR                   |  | 30                            |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MARY   |  | MIDDLE B.   |  | LAST HARE  |  | 1-16-80                    |  | 1:30 PM                       |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS               |  |  |  |
| Female   |  | White  |  | 10-13-27  |  | 52   |  | MONTHS DAYS                |  | HOURS MIN.                    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |                            |  |                               |  |  |  |
| Atlanta, Georgia   |  | U.S.A.   |  |   |  | Montgomery MD.   |  |                            |  |                               |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                            |  |                               |  |  |  |
| Silver Spring  |  | Holy Cross Hospital  |  | Homemaker   |  | --   |  |                            |  |                               |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. CITY OR TOWN  |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS  |  |                            |  |                               |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 9320-Lynmont Drive   |  |                            |  |                               |  |  |  |
| Maryland   |  | P.G.   |  | Adelphi   |  |  |  |                            |  |                               |  |  |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17 INFORMANT               |  | ADDRESS                       |  |  |  |
| Walter M. Collins  |  | Lillie Mae Eidson  |  | No  |  | 577-34-2486  |  | Cyrus Hare                 |  | 9320-Lynmont Dr. Adelphi, Md. |  |  |  |
| 18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                             |  | 18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                            |  |                               |  |  |  |
| 496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.   |  | HYPOXEMIA SEVERE.  |  | COR PULMONALE   |  | 34m  |  |                            |  |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |  |   |  | 34m.   |  |                            |  |                               |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |                            |  |                               |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                            |  |                               |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                            |  |                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                            |  |                               |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |                            |  |                               |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY                     |  | STATE                         |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET  |  |  |  |                            |  |                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 1977, to January 1980, that (I) (we) last saw the deceased alive on 16 January 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                            |  |                               |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |                            |  |                               |  |  |  |
| HAROLD I. PASSES M.D.  |  |  |  | 16 Jan 1980   |  |  |  |                            |  |                               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |                            |  |                               |  |  |  |
| HAROLD I. PASSES M.D.  |  | 4425 Montgomery Ave Bethesda Md 20814  |  |   |  |  |  |                            |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | CITY OR TOWN               |  | COUNTY STATE                  |  |  |  |
| Burial   |  | 1/19/80  |  | Washington National   |  | Suitland   |  | P.G.                       |  | Md.                           |  |  |  |
| 24 FUNERAL DIRECTOR  |  | 24b. NAME  |  | 24c. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE |  |                               |  |  |  |
| Hines/Rinaldi F.H. Inc.  |  | 1800-N.H. Ave.   |  | Silver Spring Md.   |  | JAN 23 1980  |  | H. H. Hare                 |  |                               |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8002023  |  |  |  |
|---|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>John R. Hawkins</b>   |  |   |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>13</b> YEAR <b>80</b>                                |  |   |  | 2b. HOUR <b>9:05A</b>                                       |  |  |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>CAUCASIAN</b>   |  | 5 DATE OF BIRTH MONTH <b>2</b> DAY <b>6</b> YEAR <b>08</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>   |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  | 7. IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b> MD.                               |  |   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSING</b>  |  |   |  |  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Rockville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>4306 Prince Road</b>   |  |   |  |  |  |
| 14 FATHER'S NAME FIRST <b>CLINTON</b> MIDDLE <b></b> LAST <b>HAWKINS</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>GERTRUDE</b> MIDDLE <b>A.</b> LAST <b>LARMON</b>   |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>578013970</b>   |  | 17 INFORMANT ADDRESS <b>ERNESTINE WOLF 4306 PRINCE RD., ROCKVILLE, MD.</b>                   |  |   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4912</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchitis</b> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>80</b> to <b>1/13</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Joel Schulman</b>   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>1/13/80</b>   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joel Schulman</b>  |  |   |  | 22e. ADDRESS <b>9410 Old Georgetown Rd Bethesda</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>1-16-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MONOCACY CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEALLSVILLE MONTG. MD.</b>                        |  |   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY</b> ADDRESS <b>ROCKVILLE MD.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>   |  |   |  |   |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Richard L. HAYES  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 10 1980                 |   |  | 2b. HOUR<br>8:47P M  |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 28, 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dentist  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public Health Service   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. CITY OR TOWN<br>Montgomery  |   | 13c. CITY OR TOWN<br>Bethesda                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ned Hayes  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lydia Curtis          |   |  | 16. STREET ADDRESS<br>4624 Edgefield Road  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT<br>ADDRESS<br>1618 Abingdon Dr.<br>Mrs. Zulma A. Hayes, Alexandria, Va.   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gross Negative Sepsis</u><br><u>1629</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>cat cell CARCINOMA</u><br>(c) <u>CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 8</u> , 19 <u>80</u> , to <u>Jan. 10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Jan. 10</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                      |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Timothy J. Spurling MD</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>Jan. 11 1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Timothy J. Spurling M.D.</u>   |  |  |  |   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>1-12-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Robt. A. Pumphrey Funeral Home, Bethesda, Md   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Timothy J. Spurling</u>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

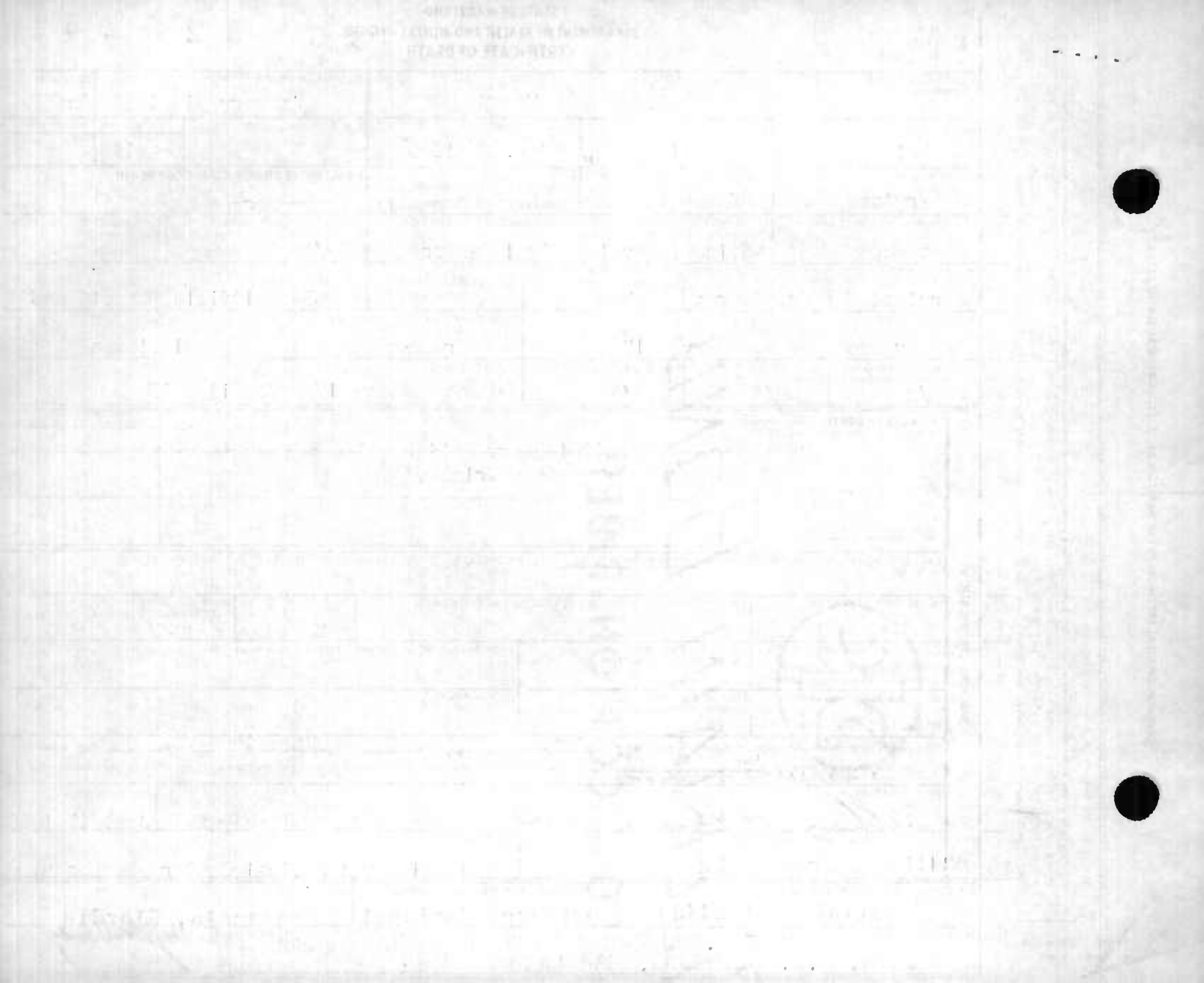
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.   |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eugene P. HAYS V   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 16 1980   |   | 2b. HOUR<br>7:50P M  |  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 6 1980   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>10                             |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>Pr. George  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>5634 Whitfield Chapel Road                |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eugene P. Hays IV   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Middleton   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>Eugene P. Hays IV See item 13   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congenital heart malformation secondary to</u><br><u>7582</u> DUE TO, OR AS A CONSEQUENCE OF <u>Trisomy 18</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I/this hospital) attended the deceased from <u>Jan. 5</u> , 19 <u>80</u> , to <u>Jan. 16</u> , 19 <u>80</u> , that (I/ (we) lost saw the deceased alive on <u>Jan. 16</u> , 19 <u>80</u> , and that in (my/ (our) opinion death occurred on the date and hour and from the causes stated above. (I/ (we) did/ (did not) view the body after death.                       |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>William A. Brown M.D.</u>  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>Jan. 17, 1980  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William A. Brown, M.D.   |  |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>1/24/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Barrances National                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pensacola, Florida |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY<br>HOMES, P.A. BETHESDA, MARYLAND  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1980   |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |   |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A13 ME (5))  
15M 7/77

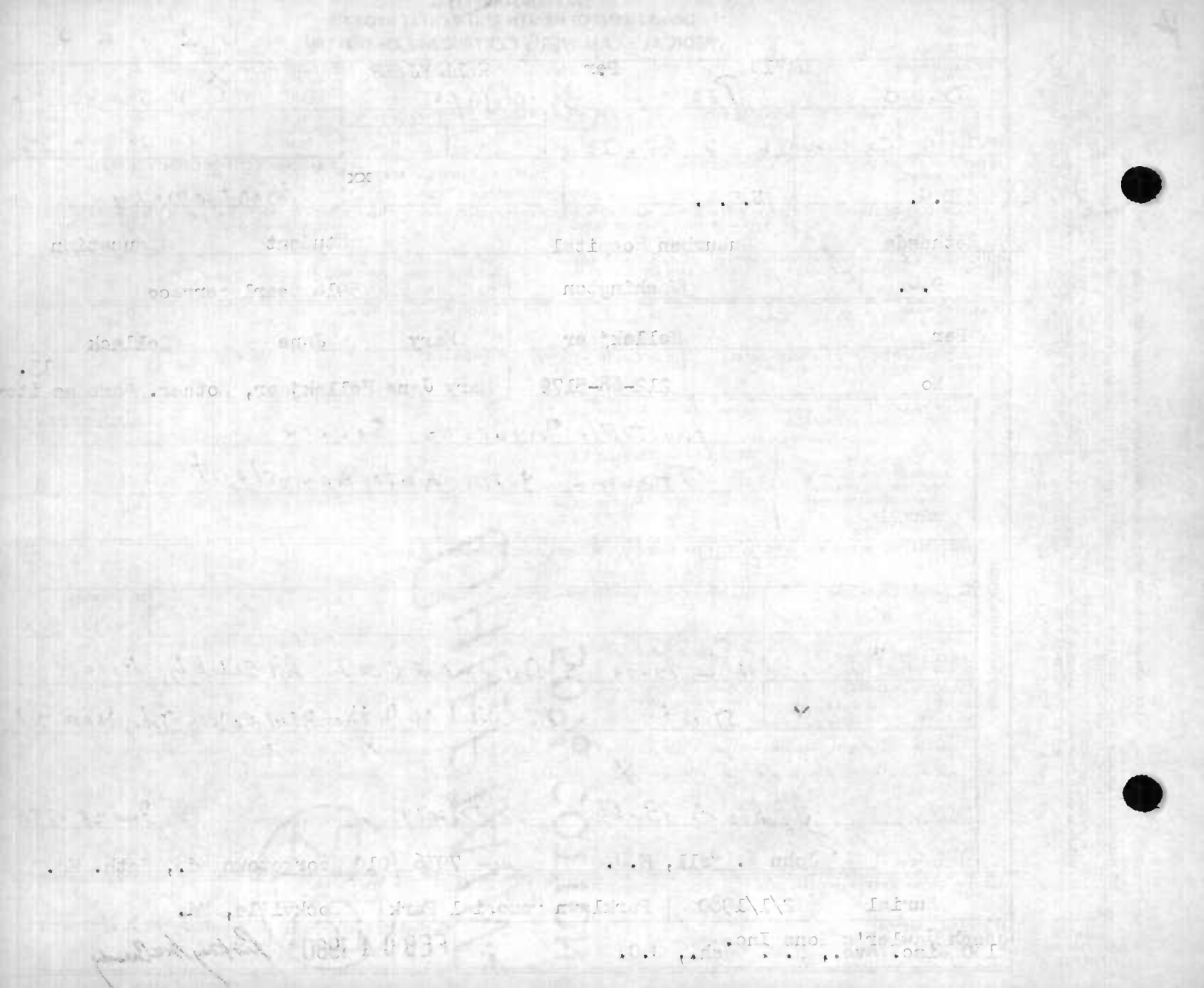
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02026

1- FOR  
STATE  
REGISTRAR

|   |                             |  |  |  |  |   |                                    |   |                           |
|---|-----------------------------|--|--|--|--|---|------------------------------------|---|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>David</b>   |                             | FIRST <b>DAVID</b>   |  | MIDDLE <b>PER</b>  |  | LAST <b>HELLEKJAER</b>  |                                    | 26. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1 28 1980 248 PM |                           |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 2 68</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>21</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | IF UNDER 24 HRS.  |                                    | 27. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 28 1980</b>                            | 28. HOUR<br><b>248 PM</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                   |                                    |   |                           |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b> |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                     |                           |
| 13a. STATE<br><b>D.C.</b>   |                             | 13b. COUNTY<br><b>Washington</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>5916 Searl Terrace</b>                                |                                    |   |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Per Hellekjaer</b>   |                             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Jane Selleck</b>  |  |   |                                    |   |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                             | 16b. SOCIAL SECURITY NO.<br><b>212-68-5179</b>   |  | 17. INFORMANT ADDRESS<br><b>Mary Jane Hellekjaer, Mother. Same as ite</b>  |  |   |                                    |   |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries Severe.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>8150 Trauma from Auto Accident.</b><br>(b)<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |  |  |  |  |   |                                    |   |                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |  |  |  |  |   |                                    |   |                           |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |                           |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 PM 12-28 1979</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Lost control of auto. hit utility pole</b>                           |  |   |                                    |   |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8700 Block McArthur Blvd Cabin John Mont Md</b>  |  |   |                                    |   |                           |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                             |  |  |  |  |   |                                    |   |                           |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |                             | TITLE (SPECIFY)<br><b>Deputy</b>   |  | MEDICAL EXAMINER   |  |   | DATE SIGNED<br><b>Jan 28, 1980</b> |   |                           |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball, M.D.</b>   |                             | ADDRESS<br><b>7936 Old Georgetown Rd., Beth. Md.</b>   |  |  |  |   |                                    |   |                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                             | 23b. DATE<br><b>2/1/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Md.</b>             |                                    |   |                           |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc.</b><br><b>5130 Wisconsin Ave., N.W. Wash., D.C.</b>  |                             |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                           |                                    |   |                           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  | REG. NO. 80 02027   |  |   |  |                              |  |
|---|--|--|---|--|--|---|--|--|--|---|--|---|--|------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR                     |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Sharon Lynne Henry  |  |  |   |  |  |   |  |  |  | January 12, 1980  |  |   |  | 11:34 A M                    |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>08/21/1963   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>16 YRS  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS          |  | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |   |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Clinical Center, NIH |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dependent  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-- |  |                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Pr. 13c. CITY OR TOWN George Friendly   |  |  |   |  |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br>1801 Folk Drive |                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Martin J. Henry, Jr  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Barbara J. Godlewski |   |  |  |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>---   |  |  | 17. INFORMANT ADDRESS<br>Martin Henry, father (Same as above)   |  |  |  |   |  |   |  |                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Right Heart Failure</u><br>7469<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A V Canal Congenital Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days   |  |  |   |  |  |   |  |  |  |   |  |   |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |  |   |  |   |  |                              |  |
| 19a. DATE OF OPERATION<br>01/10/80  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Heart Disease   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 January</u> , 19 <u>80</u> , to <u>12 January</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12 January</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death. |  |  |   |  |  |   |  |  |  |   |  |   |  |                              |  |
| 22b. SIGNATURE<br><i>Karl Jon Karlson MD</i>  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br>1/12/80  |   |  |   |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL JON KARLSON, MD   |  |  |   |  |  | 22e. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Md  |  |  |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>16Jan1980  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cem.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton PG Md.   |   |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert E. Wilhelm ADDRESS Suitland, Md.  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 2 1980   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Dorothy McCreedy</i>  |   |  |   |  |                              |  |

TO THE DIRECTOR  
OF THE  
BUREAU OF  
THE  
NAVY  
WASHINGTON  
D.C.

1-1-12

1-1-12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |  | REC. NO. 02028  |  |   |  |
|---|--|------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Gary Brooks Herbold  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Jan. 9 1980            |  | 2b. HOUR<br>A M                                   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 15 1948  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Jan. 10 1980  |  | 2d. HOUR<br>9 <sup>45</sup> A M                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Derwood  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7200 Millicrest Terrace |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Derwood  |  |                  |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>7200 Millicrest Terrace    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George F. Herbold, Jr.  |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lola Meyner                                    |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>1967-1971   |  | 17. INFORMANT<br>George F. Herbold, Jr.   |  |   |  | ADDRESS<br>12703 Bluhill Rd. Wheaton, Md. 20906   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head -</u><br>9557<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.<br>(b) <u>Self Inflicted -</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                   |  |                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>8 am 1-9 1980  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Shot Self with 12g. shot gun |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>7200 Millicrest Terr Derwood Montgomery MD.              |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>John G. Ball  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | DATE SIGNED<br>Jan. 14 1980   |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball  |  |                  |  | ADDRESS<br>7936 Old Georgetown Rd. Bethesda, Md.  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1/14/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham, Maryland                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler   |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>John G. Ball  |  |   |  |   |  |
| 1331 Rockville Pike Rockville, Maryland 20852   |  |                  |  |   |  |   |  |   |  |   |  |   |  |

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1907-1908

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 2 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence Lorena Herrell</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-13-80</b>   |  | 2b. HOUR<br><b>2:22 PM</b>        |
| 3. SEX<br><b>Female.</b>  | 4. RACE<br><b>White.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 18, 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D. C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.                       |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Co. Retired.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Maryland.</b>  |  | 13b. COUNTY<br><b>Mont.</b>  | 13c. CITY OR TOWN<br><b>Silver Spring.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Stillions</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Miller.</b>   |   | 16. ADDRESS<br><b>Acres, Florida.</b>  |                                   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>577 30-2199</b>   |   | 17. INFORMANT<br><b>Helen Owens.</b>   |                                   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br>1560<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Gall Bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CAUSE OR CONDITION GIVEN IN PART 1:<br><b>Adenocarcinoma of Gall Bladder with metastasis to liver</b> |  |  |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FALL</b> 19 <b>75</b> , to <b>JAN. 13</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>JAN. 12</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                   |
| 22b. SIGNATURE<br><b>Albert H. Grollman MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><b>1/13/80</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERT H. GROLLMAN</b>  |  |  |   | 22e. ADDRESS<br><b>1106 SPRING ST. SILVER SPRING MD</b>                              |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 16 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>                             |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bladensburg Rd. P. G. Co.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1980</b>                                  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. [Signature]</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>Robert A. [Signature]</b>   |   |  |                                   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Bureau

Jan. 10 1980 Ft. Lincoln

1980 2 13 31



No.

877 330-2199 Helen Lamm. 1975 Lake Dr. Leominster

Forest, Florida.

Carrie

Billions

Robert

Gayland. Mont. Silver Springs. 10306 Lake Wood Ave.

S. E. Md.

Thomas Park. Washington Advanced Hospital. Telephone Co. Leominster.

Washington D. C. U. S. A.

Montgomery.

White.

May 10, 1903

36



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 3 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Justine</b>   |  | FIRST<br><b>Herrmann</b>   |  | LAST  |  | 20. DATE OF DEATH MONTH DAY YEAR<br><b>January 23, 1980</b>  |  | 2b HOUR<br><b>9:35PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/29/1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fernwood House</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>18700 Walkers<br/>Choice Road, #709</b>   |  |
| 14. FATHER'S NAME<br><b>Johann</b>  |  | MIDDLE<br><b>Renauer</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Maria</b>  |  | FIRST<br><b>Ismaier</b>  |  | MIDDLE  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>090-09-2343B</b>  |  | 17. INFORMANT ADDRESS<br><b>Herbert K. Herrmann, same as #13</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thromboses, multiple</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Hypertensive Cardiovascular Disease many yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>10 months</b> |  |  |  |   |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>22 Jan 1975</b> to <b>23 Jan 1980</b> , that (I) (we) last saw the deceased alive on <b>22 Jan 1975</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michel Healy MD</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1-24-80</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michel Healy</b>  |  | 22e. ADDRESS<br><b>5411 West Cedar Lane, #205<br/>Bethesda, Maryland 20014</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/28/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Raymond's Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bronx, New York</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |  | ADDRESS<br><b>7557 Wisconsin Avenue, Bethesda, MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 7/77

| FOR<br>STATE<br>REGISTRAR   |  |         |  |  |  |                                 |  |                |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |          |  |                                   |  |  |  | REG. NO. 02031                               |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
|---|--|---------|--|--|--|---------------------------------|--|----------------|--|--|--|---|--|----------|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         |  |  |  |                                 |  |                |  | 2a. DATE KNOWN OF DEATH  |  |   |  |          |  |                                   |  |  |  | 2b. HOUR                                     |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Betty Barbara Hicks   |  |         |  |  |  |                                 |  |                |  | 1 24 1980  |  |   |  |          |  |                                   |  |  |  | 11 PM  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                                      |  | 7d. HOUR |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| F   |  | W       |  | 9 13 18  |  | 61 YRS.                         |  | MONTHS         |  | DAYS   |  | 1 24 1980   |  | 11 PM    |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |                                 |  | 8. MARRIED     |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |          |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Michigan  |  |         |  | USA  |  |                                 |  | WIDOWED        |  |  |  | Montgomery MD.  |  |          |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                                 |  |                |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |          |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Rockville   |  |         |  | Veers Mill Rd + Chappet St                               |  |                                 |  |                |  |  |  | Housewife   |  |          |  | Home                              |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |         |  |  |  |                                 |  |                |  | 13b. COUNTY  |  |   |  |          |  |                                   |  |  |  | 13c. CITY OR TOWN                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Maryland  |  |         |  |  |  |                                 |  |                |  | Montgomery   |  |   |  |          |  |                                   |  |  |  | Rockville                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |         |  |  |  |                                 |  |                |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |          |  |                                   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 17. INFORMANT     |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Pierre  |  |         |  |  |  |                                 |  |                |  | Herr   |  |   |  |          |  |                                   |  |  |  | Ruth   |  |  |  |  |  |  |  |  |  | Camp  |  |  |  |  |  |  |  |  |  | 16a. No           |  |  |  |  |  |  |  |  |  | 16b. 382 16 1034    |  |  |  |  |  |  |  |  |  | 17. Barbara Hicks |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |  |  |                                 |  |                |  | 19. DATE OF OPERATION  |  |   |  |          |  |                                   |  |  |  | 20. AUTOPSY?                                 |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY:   |  |         |  |  |  |                                 |  |                |  | 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                  |  |   |  |          |  |                                   |  |  |  | 21b. TIME OF INJURY                          |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 8129 IMMEDIATE CAUSE (a) Multiple Injuries - Severe   |  |         |  |  |  |                                 |  |                |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |          |  |                                   |  |  |  | 10 40 P.M. 1. 24 1980                        |  |  |  |  |  |  |  |  |  | Car - head on collision   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |         |  |  |  |                                 |  |                |  | (b) Trauma Auto Accident   |  |   |  |          |  |                                   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF               |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| (c)   |  |         |  |  |  |                                 |  |                |  |  |  |   |  |          |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |         |  |  |  |                                 |  |                |  |  |  |   |  |          |  |                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |         |  |  |  |                                 |  |                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                        |  |   |  |          |  |                                   |  |  |  | 21f. LOCATION                                |  |  |  |  |  |  |  |  |  | 21g. LOCATION   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK   |  |         |  |  |  |                                 |  |                |  | NOT WHILE AT WORK  |  |   |  |          |  |                                   |  |  |  | Street                                       |  |  |  |  |  |  |  |  |  | Veers Mill Rd + Chappet - Rockville Mont.                                     |  |  |  |  |  |  |  |  |  | Md.               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an   |  |         |  |  |  |                                 |  |                |  | Autopsy  |  |   |  |          |  |                                   |  |  |  | Inspection                                   |  |  |  |  |  |  |  |  |  | Inquiry   |  |  |  |  |  |  |  |  |  | and in my opinion |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| death resulted from:  |  |         |  |  |  |                                 |  |                |  | Natural causes   |  |   |  |          |  |                                   |  |  |  | Accident                                     |  |  |  |  |  |  |  |  |  | Suicide   |  |  |  |  |  |  |  |  |  | Homicide          |  |  |  |  |  |  |  |  |  | Undetermined manner |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |         |  |  |  |                                 |  |                |  | John G. Ball   |  |   |  |          |  |                                   |  |  |  | TITLE (SPECIFY)                              |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED       |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |  |  |                                 |  |                |  | John G. Ball   |  |   |  |          |  |                                   |  |  |  | ADDRESS                                      |  |  |  |  |  |  |  |  |  | Old Georgetown Rd. Bethesda, Md.  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |  |  |                                 |  |                |  | 23b. DATE  |  |   |  |          |  |                                   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY           |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |  |  |  |  |  |  |  |  | CITY OR TOWN      |  |  |  |  |  |  |  |  |  | COUNTY              |  |  |  |  |  |  |  |  |  | STATE             |  |  |  |  |  |  |  |  |  |
| Cremation   |  |         |  |  |  |                                 |  |                |  | 1/25/80  |  |   |  |          |  |                                   |  |  |  | Metropolitan Crematory                       |  |  |  |  |  |  |  |  |  | Alexandria, Virginia  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |  |  |  |                                 |  |                |  | Tyson Wheeler Funeral Home, Inc.   |  |   |  |          |  |                                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 1331 Rockville Pike Rockville, Maryland 20852   |  |         |  |  |  |                                 |  |                |  |  |  |   |  |          |  |                                   |  |  |  | JAN 28 1980                                  |  |  |  |  |  |  |  |  |  | [Signature]   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |





FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 3 2  
REG. NO.

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Estelle B Hillman</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 27 80</b>   |  | 2b. HOUR<br><b>9:00</b> AM  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 21, 1914</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASS.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Yamins</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rae I. Goldstein</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-48-3911</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Susan Canter, Gaithersburg, Maryland</b>                     |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous Cell Carcinoma Lt Kidney</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>1-17-80</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Lt Renal by Nephrectomy</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 7, 1980</b> , to <b>Jan 27, 1980</b> , that (I) (we) lost saw the deceased alive on <b>Jan 26, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |
| 22b. SIGNATURE<br><b>Wm. F. Luckett</b>   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/27/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm. F. Luckett</b>  |   | 22e. ADDRESS<br><b>5000 Reno Rd NW, Washington D. C.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Jan. 29, 1980</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Temple Beth El</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Fall River</b>  |   | COUNTY STATE<br><b>Mass.</b>  |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Mem. Chapels</b>   |   | ADDRESS<br><b>Rockville, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McCready</b>   |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

57120

Small A

5. 10. 10

12. 10. 10





FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 0 2 0 3 3  
REG. NO.

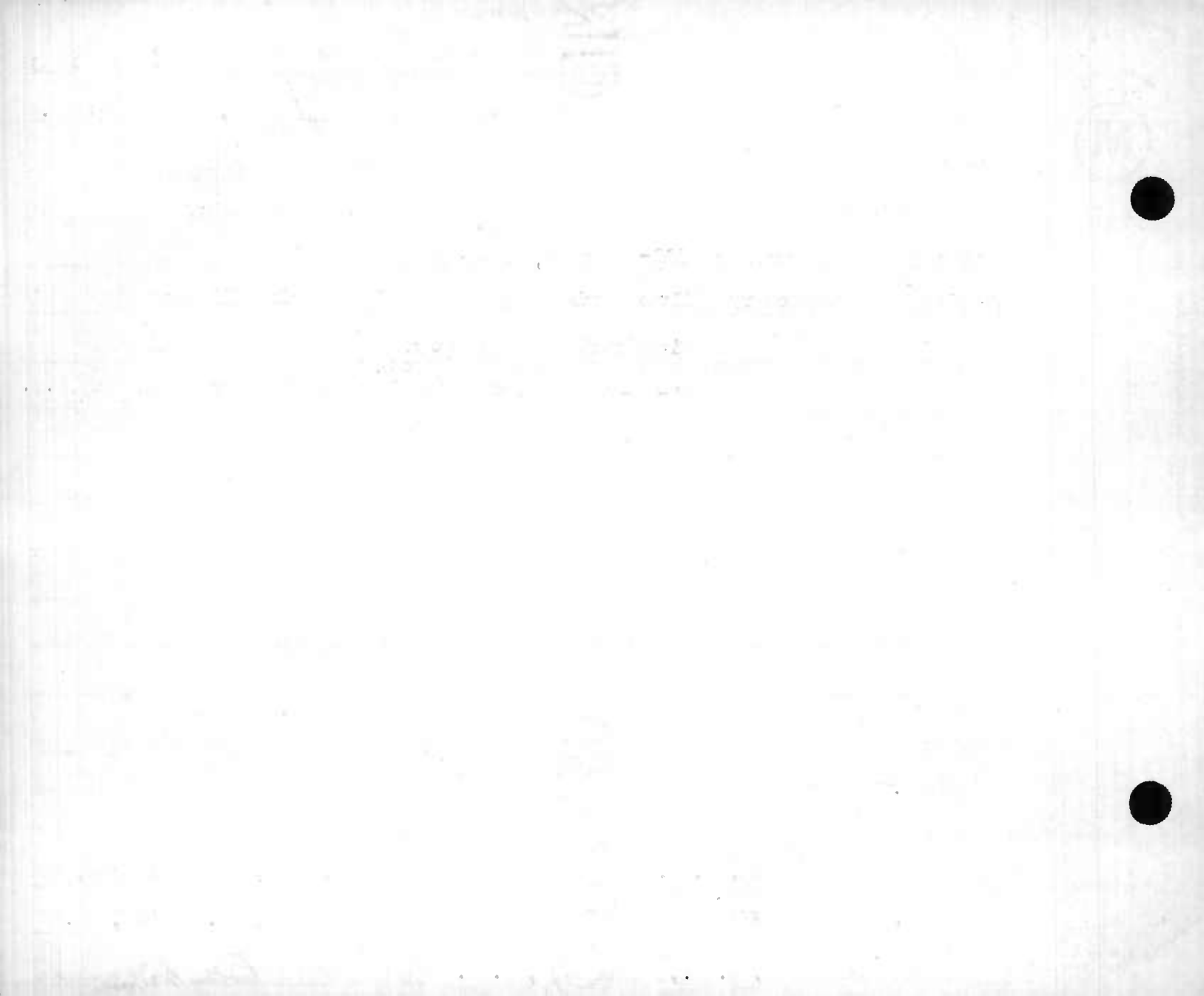
|  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Albert</b>  |  | FIRST<br><b>Himmelfarb</b>  |  | LAST<br><b>Himmelfarb</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 29, 1980</b>   |  | 2b. HOUR<br><b>8:50 P.M.</b>                                    |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 25 04</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carriage Hill-Bethesda, Cedar Lane 5215</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INVESTMENTS</b>                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>1401 Blair Mill Road</b>              |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Himmelfarb</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annetta Leibov</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-10-9794</b>   |  | 17 INFORMANT (brother) ADDRESS<br><b>Alvin Himmelfarb 9039 Sligo Creek Pkwy, S.S. MARYLAND</b>  |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>prostate carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>terminal</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from <b>19 77</b> to <b>1-29 80</b> , that (I) <b>lost</b> saw the deceased alive on <b>1-29 80</b> , and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above. (I) <b>did not</b> view the body after death.  |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><b>George Sengstack M.D.</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>1-29-80</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE SENGSTACK, M. D.</b>  |  | 22e. ADDRESS<br><b>9241 COLUMBIA BOULEVARD, SILVER SPRING, MD.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/3/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>B' NAI ISRAEL CONGREGATION CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OXON HILL, PR. GEORGES, MD.</b>   |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pickney, M. B. B.</b>   |  |  |  |   |  |

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



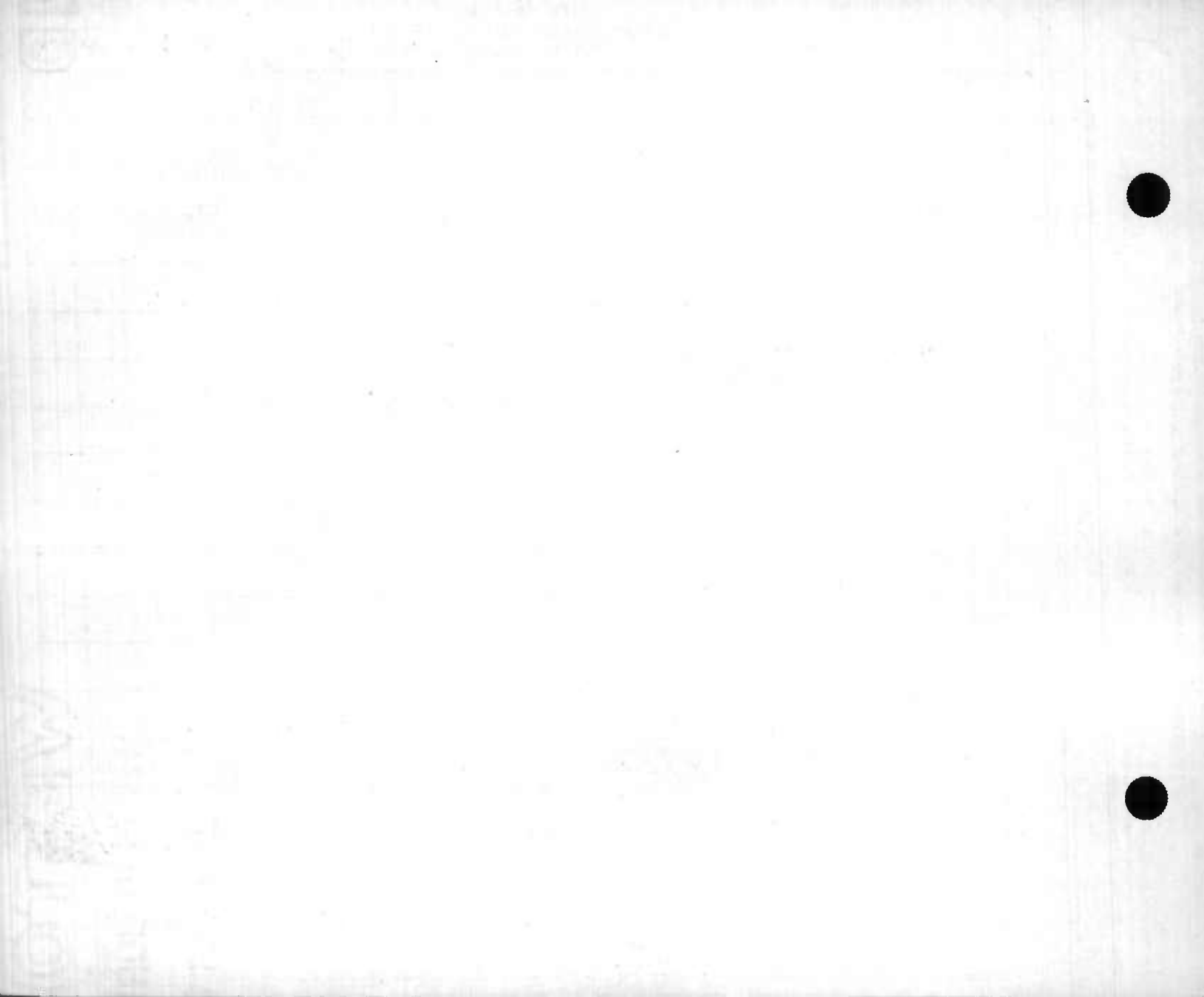


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 0 2 0 3 4<br>REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| Ruth   |  |  |  |   |  | Holmes  |  | 1-28-80  |  | 12 46 M                                      |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR IF UNDER 24 HRS              |  |
| Female   |  | White  |  | Mar. 10, 1900   |  |   |  | 79 YRS.  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |  |  |
| Wash., D.C.  |  | USA  |  |   |  |   |  | Montgomery, MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Silver Spring  |  | Holy Cross Hospital  |  |   |  |   |  | Maritime Comm.   |  | Ret.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS                          |  |
|  |  | Wash., D.C.  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5225 Conn. Ave. N. W.  |  |  |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |  |   |  |  |  |  |  |
| William E. Holmes  |  | Mary E. Mellen   |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT  |  | ADDRESS   |  |  |  |  |  |
| No   |  | 577-58-5184M   |  | Murriel S. Paleologos   |  | 7023 Tilden Lane Rockville, Md.                                     |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) SEPTICEMIA   |  |  |  |   |  |   |  |  |  | 2 DAYS                                       |  |
| 5680 DUE TO, OR AS A CONSEQUENCE OF (b) INTESTINAL OBSTRUCTION   |  |  |  |   |  |   |  |  |  | 7 DAYS                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) INTESTINAL ADHESIONS   |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |   |  |  |  |  |  |
| PNEUMONITIS  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| N/A  |  | N/A  |  | N/A   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
|  |  | N/A  |  |   |  | N/A   |  |  |  |  |  |
| 22 I certify that (I) (this hospital) attended the deceased from August 19, 74, to 1/28/80, that (I) (we) last saw the deceased alive on 1/28/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |   |  | 22c. DATE SIGNED  |  |  |  |  |  |
| Dennis J. Hand MD  |  | MD   |  |   |  | 1/28/80   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |  |  |
| DENNIS J. HAND MD  |  | 4600 CONNECTICUT AVE NW WASHINGTON DC.   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| Burial   |  | Jan. 30, 80  |  | Cedar Hill  |  | Suitland, Prince George, Md.  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Hines/Rinaldi Funeral Home   |  | JAN 31 1980  |  |   |  | R. J. McCready  |  |  |  |  |  |
| 11800 New Hampshire Ave. Silver Spring, Md.  |  |  |  |   |  |   |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                 |   |   |                            |  |  |  |  |                                | REG. NO. 02035  |  |
|--|-----------------|---|---|----------------------------|--|--|--|--|--------------------------------|---|--|
| 1- STATE REGISTRAR   |                 |   |   |                            |  |  |  |  |                                |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>David Nelson Holsinger</i>   |                 |   |   |                            |  |  |  |  |                                | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>Jan 7, 1980</i> |  |
| 3 SEX <i>M</i>   | 4 RACE <i>W</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>Nov 14 1962</i> | 6 AGE (IN YEARS LAST BIRTHDAY) <i>17 YRS.</i>   | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN.                                | 2c. DATE PRONOUNCED DEAD <i>Jan 7 1980</i>   |  | 2b. HOUR <i>5:00 PM</i>  |                                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>  |                 |   | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>                                    |                                |   |  |
| 10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>  |                 |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>123 Laytonville Rd</i> |                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Guard</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Comsat</i>  |                                |   |  |
| 13a. STATE <i>MD</i>   |                 |   | 13b. COUNTY <i>Mont</i>   |                            |  | 13c. CITY OR TOWN <i>Gaithersburg</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>David - Holsinger</i>   |                 |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna - Nelson</i>   |                            |  | 13e. STREET ADDRESS <i>123 Laytonville Rd</i>  |  |  |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>  |                 |   | 16b. SOCIAL SECURITY NO. <i>WW II 217-10-5392</i>   |                            |  | 17. INFORMANT ADDRESS <i>Margaret F. Holsinger 123 Laytonville Rd. Gaithersburg, Md.</i>   |  |  |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Gunshot Wound of Head</i><br>9554<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                 |   |   |                            |  |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><i>None</i>   |                 |   |   |                            |  |  |  |  |                                |   |  |
| 19a. DATE OF OPERATION <i>None</i>   |                 |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                            |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                 |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1 3 1980</i>  |                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Shot self</i>   |  |  |                                |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                 |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>   |                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Laytonville Rd Gaithersburg Mont MD</i>  |  |  |                                |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                 |   |   |                            |  |  |  |  |                                |   |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i>   |                 |   | TITLE (SPECIFY) <i>Deputy</i>   |                            |  | MEDICAL EXAMINER   |  |  | DATE SIGNED <i>Jan 7, 1980</i> |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, Deputy</i>  |                 |   | ADDRESS <i>1919 Seminary Rd., Silver Spring, Md.</i>  |                            |  |  |  |  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |                 |   | 23b. DATE <i>Jan. 11, '80</i>   |                            | 23c. NAME OF CEMETERY OR CREMATORY <i>Eckhart Cemetery</i> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eckhart Allegany Maryland</i>                     |                                |   |  |
| 24. FUNERAL DIRECTOR NAME <i>Robert Sandison</i> ADDRESS <i>316 E. Diamond Ave., Gaithersburg, Md.</i>   |                 |   |   |                            |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Robert Sandison</i>  |                                |   |  |

25



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 0 2 0 3 6

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy Gates Hough</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 28, 1980</b>         |   |   | 2b. HOUR<br><b>12:06 PM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 24, 1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>15709 White Rock Road</b>                          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Eugene Gates</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel Brown</b>                             |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>578 62 2372</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Col. Ernest A. Hough same as item 13</b>                         |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic heart disease Chronic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b> |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>Jan. 28, 1980</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 16, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Edward W. Nicklas, M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |   | 22c. DATE SIGNED<br><b>1/28/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward W. Nicklas, M.D.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>4830 V St. N.W. Washington, D.C.</b>                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/30/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>                                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

Cleared by Dr. Ball  
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

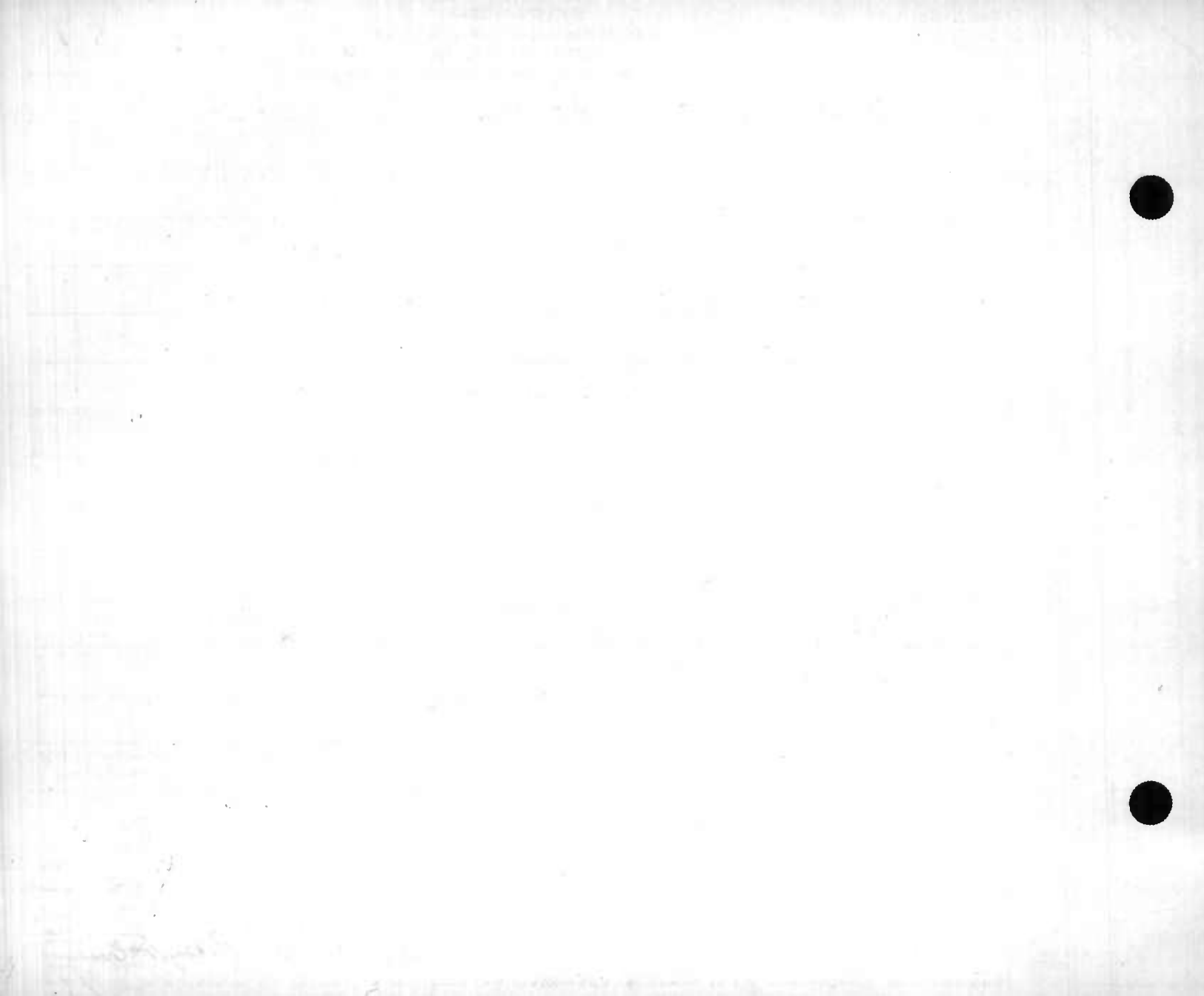
8 0 0 2 0 3 7

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Franklin G. Howell</b>                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 31 80</b>   |  | 2b. HOUR<br><b>11 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 13 1921</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Beltsville</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Howell</b>                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Violet Moore</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes WWII</b> |  | 16b. SOCIAL SECURITY NO.<br><b>051-16-5901</b>  |  | 17. INFORMANT<br><b>Virginia Howell</b><br>ADDRESS<br><b>13205 Greenmont Ave<br/>Beltsville, Md. 20705</b>      |  |

|  |  |  |
|--|--|--|
| <b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Acute renal failure</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Days</u> |
| 2506<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hepatic failure</u> |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                    |

|  |  |  |  |
|--|--|--|--|
| PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>① Diabetes mellitus      ② Cirrhosis of liver      ③ Cholelithiasis  |  |  |  |
| 19a. DATE OF OPERATION<br>1/7/80   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GANGRENE of FOOT   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK    NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET  | CITY OR TOWN      COUNTY      STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/38, 1979, to 1/31, 1980, that (we) lost<br>saw the deceased alive on 1/31, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Norman H. Rubenstein M.D.  | DEGREE<br>M.D.   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>2/1/80   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Norman H. Rubenstein MD   |  | 22e. ADDRESS<br>11161 New Hampshire Ave. Silver Spring,  |  |

|  |                           |  |   |  |       |
|--|---------------------------|--|---|--|-------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>Feb. 4, 1980 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cemetery<br>Pine Lawn Memorial | 23d. LOCATION<br>CITY OR TOWN<br>Wantheh, Long Island, New York | COUNTY                                       | STATE |
| 24. FUNERAL DIRECTOR<br>Name/Rinaldi Funeral Home      |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 04 1980                    | 25b. REGISTRAR'S SIGNATURE<br>P. J. McCreedy |       |
| 11800 New Hampshire Ave., Silver Spring, Md.           |                           |  |   |  |       |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert John HUME  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 20 1980                         |  | 2b. HOUR<br>6:20a <sub>M</sub>   |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 24 1926   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Rock County, Wis.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Navy  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Virginia   |  |   | 13b. COUNTY<br>Fairfax   |  | 13c. CITY OR TOWN<br>Falls Church  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John NMN Hume  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Boyd                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1945-1973  | 17. INFORMANT<br>ADDRESS Falls Church, VA<br>Betty J. Hume 2830 Winchester Way |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>3500 IMMEDIATE CAUSE (a) Diabetes Mellitus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic Coronary Artery Disease<br>and<br>(c) Intramural, Mesentery and Bladder Hemorrhage                         |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICALEXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 19 80, to Jan. 20 19 98, that I (we) lost<br>saw the deceased alive on Jan. 20 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br>Marina Nikki Vernalis DEGREE   |  |   |  | 22c. DATE SIGNED<br>1/21/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marina Nikki Vernalis, M.D.   |  |   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 23, 1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Arlington Funeral Home   |  | ADDRESS<br>3901 N. Fairfax Dr.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |  |  |
|--|--|---|---|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO. 80 02039   |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLIET H. HUNTER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-28-80</b>  |   |   | 2b. HOUR<br><b>11:20 A.M.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 26 1885</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Wheaton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Randolph Hills Nursing Home</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland Montgomery Wheaton</b>   |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13c. STREET ADDRESS<br><b>4011 Randolph Road,</b> |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jacob W. Hardy</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mammie Long</b>                                |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>none</b>   |   | 17. INFORMANT ADDRESS<br><b>207 Lee Street, Clark-Bland F.H. Johnston, S. Carolina</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic heart failure</b><br>(c) <b>Arterio sclerotic cardiovascular d.</b> |  |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b><br><b>years.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Brain syndrome</b>   |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> , 19 <b>74</b> , to <b>1/28</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>1/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE <b>James R. Coleman</b>   |  |   |   | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-28-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES R. COLEMAN</b>   |  |   |   | 22e. ADDRESS<br><b>9241 COLUMBIA BLVD SILVER SPRING, MD 20910</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-31-80</b>   |   | 23c. NAME OF CEMETERY OR MONUMENTARY PK.<br><b>Sunset Gardens</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Johnston Edgefield S.C.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc</b><br><b>8434 Ga. Ave., S.S. Md.</b>   |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 31 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>M. G. Brooks</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 8002040   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALICE HUTTLER</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 20 80</b>  |  |  |  | 2b. HOUR<br><b>2<sup>1</sup></b> M   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 21 91</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chew Chase Nursing and Convalescent Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales clerk</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>D.C.</b>   |  |   |  |   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Washington</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>(Unknown) Hanner</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>(UNKNOWN)</b>                              |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>137-09-4502</b>  |  | 17. INFORMANT<br><b>Arthur C. Elgin, Jr.</b>  |  | 414 Hangerford Dr. Rockville, Md.   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Dis</b><br><b>429.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Angenic Brain Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 YRS.</b>                           |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7.7</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10/5/75</b> , 19____, to <b>1/20/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/18</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence J. Thomas M.D.</b>   |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/20/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE J. THOMAS</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>11801 ROCKVILLE PIKE Rockville, Md.</b>                                  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan. 21, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Va.</b>                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b>   |  | 24b. ADDRESS<br><b>Homes, P.A. Bethesda, Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |  |  |  |  |

BP \_\_\_\_\_



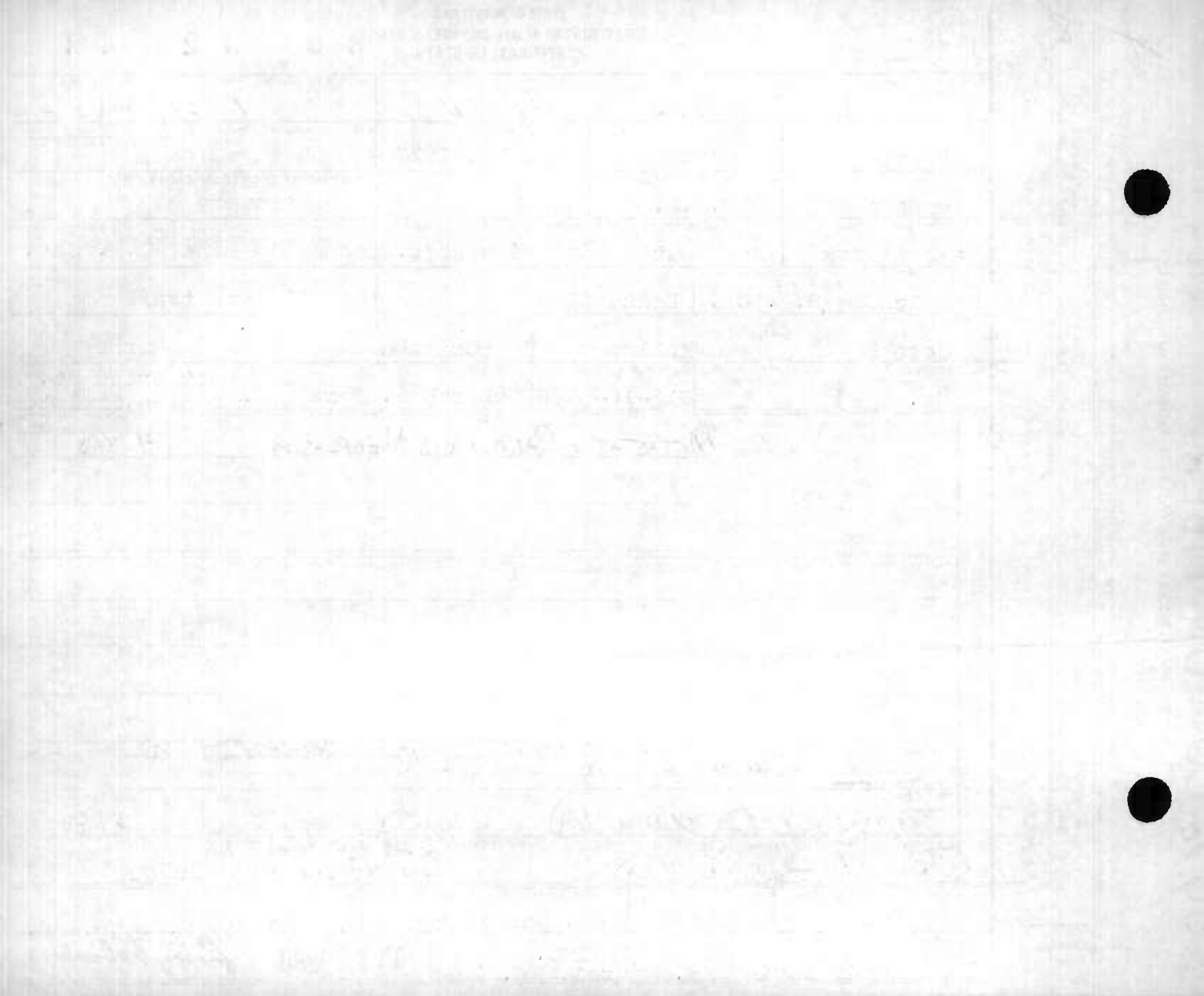


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |                                 |  |   |  |
|--|--|---|--|--|--|---|---------------------------------|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 0002041  |  |  |  |   |                                 |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NINA VERA HUMAN   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/28/80                 |   |                                 | 2b. HOUR<br>8 A M  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 20, 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                            |                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hosp. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assembly Line |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov.   |   |  |
| 13a. STATE<br>Maryland   |  |   |  |  | 13b. COUNTY<br>P.G. Co.  |   | 13c. CITY OR TOWN<br>Beltsville |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Holloway  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Crimson Burns |   |                                 |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.  |  | 16b. SOCIAL SECURITY NO.<br>313-18-0980   |  | 17. INFORMANT<br>ADDRESS<br>26 1/2 West Broad St.<br>West Haven, Hazleton Pa.  |  |   |                                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOID NEOPLASM<br>1991<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS |  |   |  |  |  |   |                                 |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |  |  |   |                                 |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |                                 |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 1977, to JANUARY 27, 1980, that (I) (we) lost the deceased alive on JANUARY 27, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |  |  |  |   |                                 |  |   |  |
| 22b. SIGNATURE<br>James G. Brown MD  |  |   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   |                                 | 22c. DATE SIGNED<br>1/28/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES G. BROWN MD   |  |   |  | 22e. ADDRESS<br>625 BELCAST RD<br>HYATTSVILLE MD 20782   |  |   |                                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/31/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Geo. Washington Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>P.G. Co. Md.                        |                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>FLECK LAUREL FUNERAL HOME, INC.<br>7601 Sandy Spring Rd. Laurel, Md. 20810   |  |   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 29 1980                                       |                                 | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.  |   |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 4 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRENCH MARIAN HYRE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 7, 1980</b>             |  |  | 2b. HOUR<br><b>6:30 AM</b>  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 31, 1902</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5123 Bradley Blvd.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Economist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept Agriculture</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Chevy Chase</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>5123 Bradley Blvd.</b>                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Hyre</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida May Mateney</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>577-30-7885</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>Harriet M. Hyre Same as Item # 13</b>   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma prostate</b><br><b>185-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1976</b> to <b>Jan 1980</b> , that (I) (we) last saw the deceased alive on <b>6 Jan 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Horace W. Brenton</b>   |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/7/80</b>                                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Horace W. Brenton, M.D.</b>  |  |  |  |  | 22e. ADDRESS<br><b>4743 Bradley Blvd. Ch.Ch., Md.</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/10/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lawnwood Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Morgantown, W.Va.</b> |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1980</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pitney McCreedy</b>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8002043

|   |  |   |   |  |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>DUNNING IDLE</b>  |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 12 '80</b>                 |  |  | 2b HOUR<br><b>7:00 AM</b>  |  |  |  |
| 3 SEX<br><b>male</b>  |  | 4 RACE<br><b>CAUCASIAN</b>  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>JAN. 6 - 1905</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>INDIANA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br><b>MARYLAND</b>   |  |   | 13b COUNTY<br><b>MONT. GAITHERSBURG</b>                               |  | 13c CITY OR TOWN<br><b>BETHESDA</b>                          |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DUNNING IDLE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE BANKS</b>  |  |  | 16 ADDRESS<br><b>617 GOLDSBOROUGH</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>264-50-3475A</b>  |   | 17 INFORMANT<br><b>DUNNING IDLE IV - DR. ROCKVILLE MD</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intractable Congestive Heart Failure</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Previous Myocardial Infarction</b> |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 day</b><br><b>year</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/4/80</b> 19____, to <b>1/12/80</b> 19____, that (I) (we) last saw the deceased alive on <b>1/11/80</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.    |  |   |   |  |  |  |  |  |  |
| 22b SIGNATURE<br><b>G. Stuart Scott</b>   |  |   | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>1/12/80</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR G STUART SCOTT</b>  |  |   | 22e ADDRESS<br><b>10401 OLD GEORGETOWN RD, BETHESDA MD</b>            |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>CREMATION</b>  |  |   | 23b DATE<br><b>1/14/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREM.</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND - P.G. MD.</b>                        |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>W. W. CHAMBERS CO.</b>  |  |   | ADDRESS<br><b>SILVER SPRING MARYLAND</b>                              |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 16 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>William H. H. H.</b>   |  |

W W Grammer Co. Maryland  
 14001 Old Georgetown Rd. Bethesda  
 Dr. E. Stuart Scott

No  
 Dunning T Die Bessie  
 Maryann West Grammer &  
 Education Teacher

Indiana USA  
 Caucasian Jan 6. 1902  
 Dunning T Die



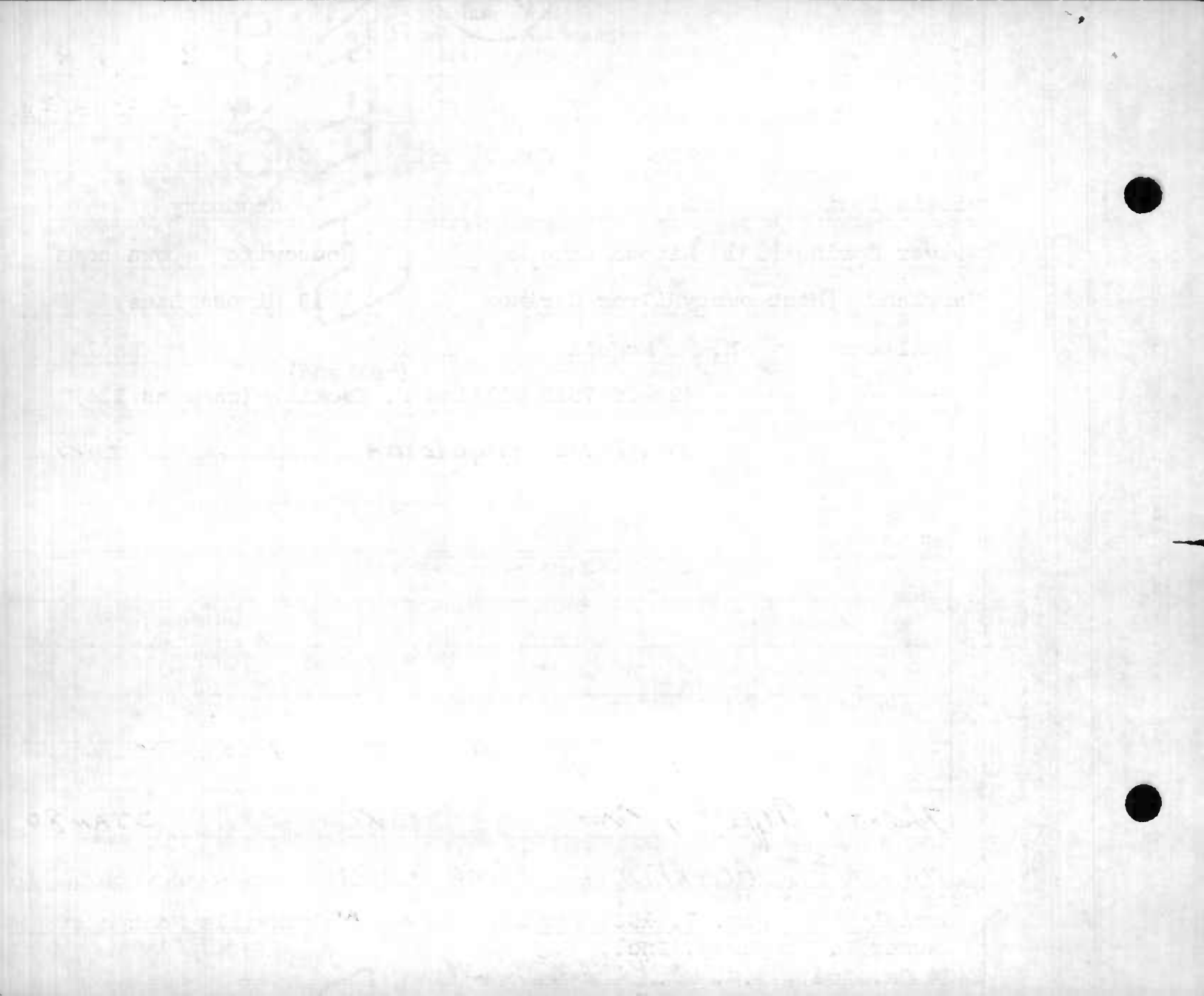
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 0 2 0 4 4  
REG. NO.

|   |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGIE M. ISOKAIT</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 3 80</b> |  |  | 2b HOUR<br><b>3:30 AM</b>  |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>white</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 2, 1926</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1318 Mimosa Lane</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>        |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>  |   | 13c CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1318 Mimosa Lane</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William a.H. McNeil</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Dauls</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>-----</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>428-36-7513</b>   |   | 17 INFORMANT (husband) ADDRESS<br><b>William F. Isokait-(same as 13e)</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>multiple myeloma</b><br><b>2030</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs.</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MAY 30</b> , 19 <b>75</b> , to <b>1-3</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>Hubert J. Alpert, M.D.</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |  | 22c DATE SIGNED<br><b>3 JAN 80</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hubert J. Alpert, M.D.</b>   |  |  |   | 22e ADDRESS<br><b>8630 Fenton St. Silver Spring, Md.</b>   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>Jan. 7, 1980</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville Montgomery Md</b>                |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.,</b><br><b>8434 Ga. Ave., S.S. Md.</b>   |  |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 9 1980</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |   |   |  |
|---|--|--|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  | Irene A. Jack  |  |  |   | REG. NO. 80 02045  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Irene A. Jack</b>   |  |  |  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |   | 2b. HOUR                                     |
|   |  |  |  |  | 11/4/80   |  | 7:22  |   | M  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W.</b>  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                                       |  |
|   |  |  |  | 2/16/17  |   | 62 YRS   |   | MONTHS DAYS HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>315-West Side Drive #301</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Clerk</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Gaithersburg</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>315- West Side Drive # 301</b> |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |   |  |
| FIRST MIDDLE LAST <b>Nell - Boudreau</b>  |  |  |  | FIRST MIDDLE LAST <b>Mary Unknown</b>  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO <b>051-32-7285</b>   |   | 17. INFORMANT ADDRESS <b>James G. Jack, Jr. (Son) Same as above # 13</b>                     |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY   |  |  |  |  |   |  |   |   | 2 YRS  |
| IMMEDIATE CAUSE (a) <b>Conc</b>   |  |  |  |  |   |  |   |   |  |
| 1749 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Local Failure</b>   |  |  |  |  |   |  |   |   | 2 hrs  |
| DUE TO, OR AS A CONSEQUENCE OF <b>ca R R EAST</b>   |  |  |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |   | CITY OR TOWN   |   | COUNTY  | STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>79</b> , to <b>1/3</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE <b>G. S. Seiden</b>  |  |  |  | DEGREE <b>M.D.</b>   |   |  |   | 22c. DATE SIGNED <b>Jan. 5, 1980</b>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD H. LEVINE</b>   |  |  |  | 22e. ADDRESS <b>8630 Fenton St. Silver Sp., Md.</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>Jan. 6, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>  |   | 23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY STATE                              |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>J.Wm. Lee's Sons Co.</b>   |  |  |  | ADDRESS <b>300-4th St., NE, Wash., DC 20002</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Pickney McCreedy</b>    |  |

James A. Jack

Montgomery

24

United States

Montgomery

Retired-Jack

312 West Side Drive #301

Gettersburg

312 West Side Drive #301

2

Gettersburg

Montgomery

Maryland

Unknown

None

Boudreau

Neil

001-31-1202 James A. Jack, Jr. (son) Same as above 12

10

Jan. 5, 1960

6030 Renton St. Silver Sp., Md.

Washington, D.C.

Jan. 6, 1961 Lee's Research

Information

J. M. Lee's 1000-4th St., Wash., D.C. 20000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17  
(VR AT 15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02046

1- FOR  
STATE  
REGISTRAR

|  |  |                  |               |   |  |   |  |   |                 |  |  |   |  |  |                      |  |  |
|--|--|------------------|---------------|---|--|---|--|---|-----------------|--|--|---|--|--|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>EMMA |   |  | MIDDLE<br>E.  |  |   | LAST<br>JACKSON |  |  | 20. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI-<br>MATED <input type="checkbox"/> 1/5/80 |  |  | 21. HOUR<br>11:39 AM |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 22, 1907   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>72 YRS.                   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                 | 7. DATE<br>PRONOUNCED<br>DEAD Jan. 5 1980                              |  | 24. HOUR<br>11:39 AM  |  |  |                      |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Va.  |  |                  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO.  |  |  |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  |                  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY OR COUNTY)<br>SUBURBAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Unemployed  |                 |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |                      |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Kensington  |  |                  |               |   |  |   |  |   |                 |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 13e. STREET ADDRESS<br>4107 Pliers Mill Rd. Apt. 101 |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Keith   |  |                  |               |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maria F. Smith |  |   |                 |  |  |   |  |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |                  |               | 16b. SOCIAL SECURITY NO.<br>579-28-8137   |  |   |  | 17. INFORMANT<br>ADDRESS<br>Philip Jackson (Husband) same as #13  |                 |  |  |   |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Obesity</u> |  |                  |               |   |  |   |  |   |                 |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH      |                      |  |  |
| 19a. DATE OF OPERATION   |  |                  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |                 |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |  |                      |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                 |  |  |   |  |  |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |               | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                 |  |  |   |  |  |                      |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |  |                  |               |   |  |   |  |   |                 |  |  |   |  |  |                      |  |  |
| ACTUAL<br>SIGNATURE <u>John G. Ball</u>  |  |                  |               | TITLE (SPECIFY)<br>M.D. <u>Deputy</u>   |  |   |  | MEDICAL EXAMINER  |                 |  |  | DATE<br>SIGNED Jan 5, 1980  |  |  |                      |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |               | ADDRESS   |  |   |  |   |                 |  |  |   |  |  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |               | 23b. DATE<br>1-10-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mutual Memorial Cem.      |  |   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sandy Spring, Montg. Md. |  |   |  |  |                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George R. Snowden  |  |                  |               |   |  | 24b. ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850   |  |   |                 | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1980                            |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John G. Ball</u>    |                      |  |  |

BP

112100

Female, Black, 1917-75

Unemployed

Unemployed

Unemployed

Unemployed

Unemployed

Unemployed

Unemployed

Unemployed (husband) same as 17

278-28-0137

Unemployed (husband) same as 17

Unemployed (husband) same as 17

Unemployed (husband) same as 17

Unemployed (husband) same as 17

Unemployed (husband) same as 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

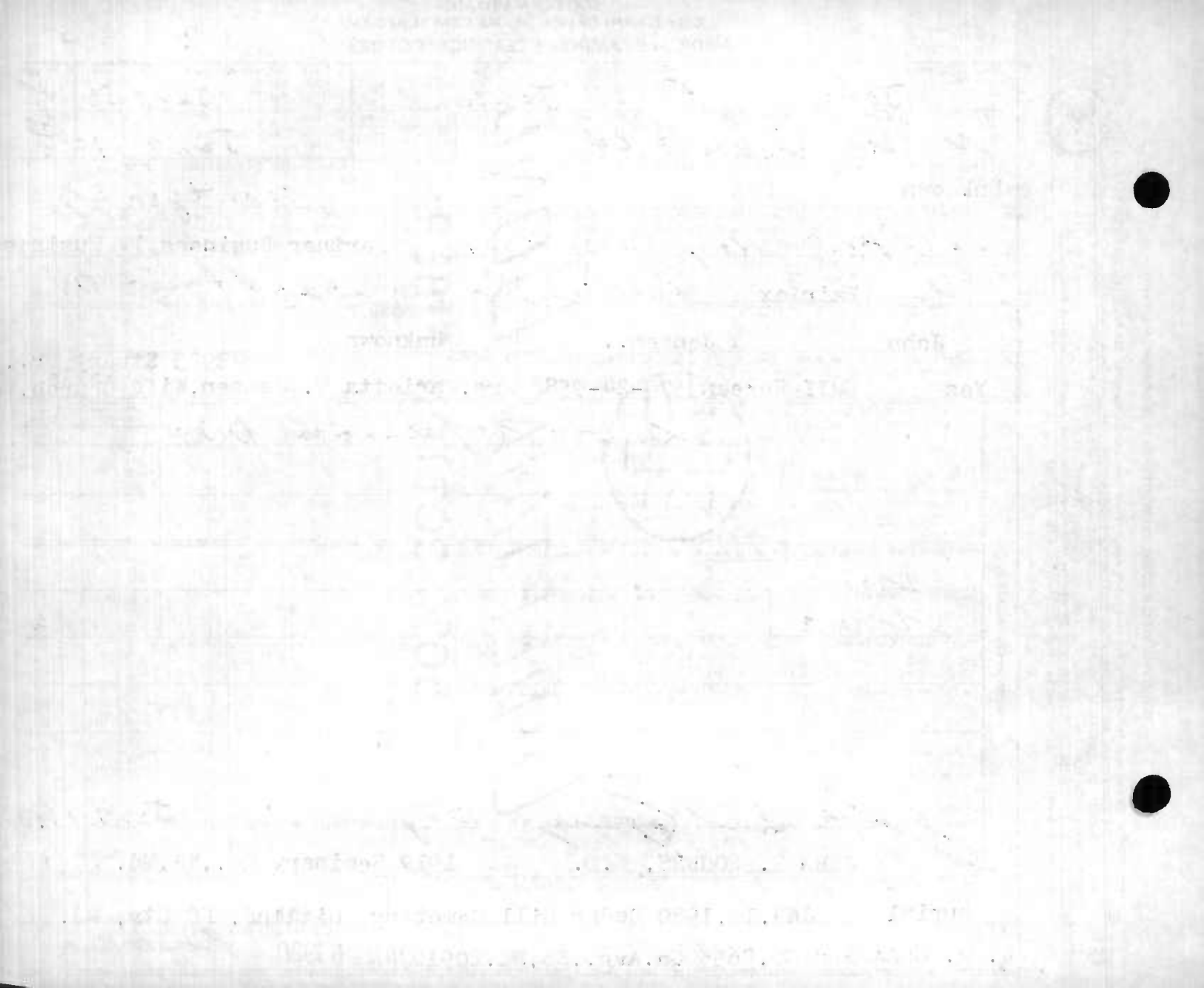
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 70 02047   |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST FRANCES MIDDLE F. LAST JACOBUS   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |  |  |
| FRANCES   |  | F. JACOBUS   |  | 1-16-80   |  | 505P M   |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS           |  |
| FEMALE  |  | White  |  | 12-31-84  |  | 95 YRS   |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |  |  |
| Illinois  |  | U.S.A.   |  |   |  | MONTGOMERY CO. MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| BETHESDA, MD.   |  | SUBURBAN HOSPITAL  |  | Homemaker   |  | At Home  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. COUNTY  |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS  |  |  |  |
| Maryland  |  | Montgomery   |  | Chevy Chase   |  | 3531 Woodbine Street   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| Auguste --- Friede  |  | Amanda --- Diesing   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| No  |  | 346-24-0766A   |  | Madalaine Jacobus, Same as # 13.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Branchiopneumonia</u>  |  |  |  |   |  |  |  | 5 days                                       |  |
| 4049 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular-Renal Disease</u>   |  |  |  |   |  |  |  | ??   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Azotemia</u>  |  |  |  |   |  |  |  | ??   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
|   |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1/15</u> , 19 <u>80</u> , to <u>1/16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED   |  |  |  |
| <u>Lawrence J. Thomas M.D.</u>  |  | M.D.   |  |   |  | <u>1/17/80</u> MD  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| LAWRENCE J. THOMAS  |  | 11801 ROCKVILLE PIKE, Rockville,   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |
| Cremation   |  | 1/18/80  |  | Cedar Hill Crematory  |  | Suitland, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 5130 Wis. Ave., N.W. ADDRESS   |  | 25a. DATE RECORDED BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Joseph Gawler's Sons, Inc.  |  | Washington, D.C. 20016   |  | JAN 21 1980   |  | <u>Barry H. Brady</u>  |  |  |  |



Caravan. Natifuel & miel affreave  
Gleane 240

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |              |  |   |   |                             |   |  |   |  |  |  | REG. NO. 02048   |  |
|--|--------------|--|---|---|-----------------------------|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>John F. Jensen   |              |  |   |   |                             |   |  |   |  |  |  | 2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>Jan 7 1980 |  |
| 3. SEX<br>M  | 4. RACE<br>W | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb 10 15 64  | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>Jan 7 1980   |  | 7d. HOUR MIN.   |  | 7e. HOUR MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Unknown   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Sil Spg.  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET CROSS ADDRESS)<br>Holy Cross Hosp |   |   |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Partner Business TV Business |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. STATE<br>Va   |              | 13b. COUNTY<br>Fairfax   |   | 13c. CITY OR TOWN<br>Falls Church   |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2923 Stuart Dr.  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Jensen..   |              |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |                             |   |  | 16. ADDRESS<br>2923 Stuart Dr., Falls Church, Va                                    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |              | 16b. SOCIAL SECURITY NO.<br>WWII Korean 579-24-9588  |   | 17. INFORMANT<br>Mrs. Marietta T. Jensen, wife of John F. Jensen  |                             |   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                              |              |  |   |   |                             |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |              |  |   |   |                             |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>None   |              |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                             |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |              |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                             |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |   |   |                             |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>John S. Rogers   |              |  |   | TITLE (SPECIFY)<br>M.D.   |                             |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>Jan 7 1980  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>JOHN S. ROGERS, M.D.  |              |  |   | ADDRESS<br>1919 Seminary Rd., SS, Md.   |                             |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |              |  |   | 23b. DATE<br>JAN 10 1980  |                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                     |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland, PG Cty, Md. |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>W. W. CHAMBERS  |              |  |   | ADDRESS<br>CO, 8655 Ga. Ave., SS, Md.   |                             |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>William W. Chambers                |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 4 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alice Virginia Johnson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 23 80</b>                               |  | 2b. HOUR<br><b>1:18AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 31, 1923</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Montgomery Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Montg.</b>   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5112 Brookeville Road</b>                                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Bowie</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Phoenix</b>             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-14-6533</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Frederick Johnson (Husband) same as #13</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASVD - A CVD - Gangrene Tels</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF <b>Diabetes Mellitus</b><br>(c) <b>Open</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2d</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital attended the deceased from <b>65</b> to <b>1/23/80</b> , that (H-we) last saw the deceased alive on <b>1/23/80</b> , and that in my opinion death occurred on the date and hour and from the causes stated above, (1) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br><b>[Signature]</b>  |  | 22c. DATE SIGNED<br><b>1/23/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. H. L. [Signature]</b>  |  | 22e. ADDRESS<br><b>1811 P + P Highway, Olney, Md. 20855</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-26-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Cemetery</b>                        |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mt Zion, Montgomery, Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>  |  |  |   |
| 24b. ADDRESS<br><b>246 N. Washington Street<br/>Rockville, Md. 20850</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>   |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 0002050   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| Burr  |  | Nello  |  | JOHNSON, JR.   |  | January 11 1980   |  | 11:22A   |  | M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7b. IF UNDER 24 HRS. HOURS MIN.              |  |
| Male  |  | Caucasian  |  | Aug. 28 1913   |  | 66  |  | YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| New York  |  | USA  |  |  |  | Montgomery MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Bethesda  |  | National Naval Medical Center  |  |  |  |   |  | Realtor/Proprietor   |  | Realtor                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS                          |  |
| Md.   |  | Montgomery   |  | estmoreland  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 5217 Westwood Drive  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |  |  |
| Burr Nello Johnson Sr.  |  | Kathleen Marie Dunn  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |  |  |
| Yes   |  | WWII   |  | 105 03 9991 Mrs. Frances S. Johnson See item 13  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u>   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES Mellitus</u>  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <u>Dec. 27</u> , 19 <u>79</u> , to <u>Jan. 11</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>Jan. 11</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.) |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |   |  |  |  |  |  |
| <u>James J. Curran MD</u>   |  | 12 JAN 80  |  |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
| JAMES J. CURRAN MD  |  | National Naval Medical Center, Bethesda, Md.   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| Burial  |  | 1/15/1980  |  | Arlington National   |  | Arlington Arlington Va.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Jos. Gawler Sons  |  | Washington, D. C.  |  | 1 JAN 16 1980  |  | <u>Robert H. H. H.</u>  |  |  |  |  |  |

S

|                                       |  |               |  |               |  |
|---------------------------------------|--|---------------|--|---------------|--|
| 1. NAME (Last, First, Middle Initial) |  | 2. GRADE      |  | 3. BRANCH     |  |
| 4. DUTY STATION                       |  | 5. DATE       |  | 6. TIME       |  |
| 7. SUBJECT                            |  | 8. ACTION     |  | 9. COMMENTS   |  |
| 10. APPROVED                          |  | 11. SIGNED    |  | 12. DATE      |  |
| 13. OFFICE                            |  | 14. DIVISION  |  | 15. BRANCH    |  |
| 16. NAME                              |  | 17. GRADE     |  | 18. BRANCH    |  |
| 19. DUTY STATION                      |  | 20. DATE      |  | 21. TIME      |  |
| 22. SUBJECT                           |  | 23. ACTION    |  | 24. COMMENTS  |  |
| 25. APPROVED                          |  | 26. SIGNED    |  | 27. DATE      |  |
| 28. OFFICE                            |  | 29. DIVISION  |  | 30. BRANCH    |  |
| 31. NAME                              |  | 32. GRADE     |  | 33. BRANCH    |  |
| 34. DUTY STATION                      |  | 35. DATE      |  | 36. TIME      |  |
| 37. SUBJECT                           |  | 38. ACTION    |  | 39. COMMENTS  |  |
| 40. APPROVED                          |  | 41. SIGNED    |  | 42. DATE      |  |
| 43. OFFICE                            |  | 44. DIVISION  |  | 45. BRANCH    |  |
| 46. NAME                              |  | 47. GRADE     |  | 48. BRANCH    |  |
| 49. DUTY STATION                      |  | 50. DATE      |  | 51. TIME      |  |
| 52. SUBJECT                           |  | 53. ACTION    |  | 54. COMMENTS  |  |
| 55. APPROVED                          |  | 56. SIGNED    |  | 57. DATE      |  |
| 58. OFFICE                            |  | 59. DIVISION  |  | 60. BRANCH    |  |
| 61. NAME                              |  | 62. GRADE     |  | 63. BRANCH    |  |
| 64. DUTY STATION                      |  | 65. DATE      |  | 66. TIME      |  |
| 67. SUBJECT                           |  | 68. ACTION    |  | 69. COMMENTS  |  |
| 70. APPROVED                          |  | 71. SIGNED    |  | 72. DATE      |  |
| 73. OFFICE                            |  | 74. DIVISION  |  | 75. BRANCH    |  |
| 76. NAME                              |  | 77. GRADE     |  | 78. BRANCH    |  |
| 79. DUTY STATION                      |  | 80. DATE      |  | 81. TIME      |  |
| 82. SUBJECT                           |  | 83. ACTION    |  | 84. COMMENTS  |  |
| 85. APPROVED                          |  | 86. SIGNED    |  | 87. DATE      |  |
| 88. OFFICE                            |  | 89. DIVISION  |  | 90. BRANCH    |  |
| 91. NAME                              |  | 92. GRADE     |  | 93. BRANCH    |  |
| 94. DUTY STATION                      |  | 95. DATE      |  | 96. TIME      |  |
| 97. SUBJECT                           |  | 98. ACTION    |  | 99. COMMENTS  |  |
| 100. APPROVED                         |  | 101. SIGNED   |  | 102. DATE     |  |
| 103. OFFICE                           |  | 104. DIVISION |  | 105. BRANCH   |  |
| 106. NAME                             |  | 107. GRADE    |  | 108. BRANCH   |  |
| 109. DUTY STATION                     |  | 110. DATE     |  | 111. TIME     |  |
| 112. SUBJECT                          |  | 113. ACTION   |  | 114. COMMENTS |  |
| 115. APPROVED                         |  | 116. SIGNED   |  | 117. DATE     |  |
| 118. OFFICE                           |  | 119. DIVISION |  | 120. BRANCH   |  |
| 121. NAME                             |  | 122. GRADE    |  | 123. BRANCH   |  |
| 124. DUTY STATION                     |  | 125. DATE     |  | 126. TIME     |  |
| 127. SUBJECT                          |  | 128. ACTION   |  | 129. COMMENTS |  |
| 130. APPROVED                         |  | 131. SIGNED   |  | 132. DATE     |  |
| 133. OFFICE                           |  | 134. DIVISION |  | 135. BRANCH   |  |
| 136. NAME                             |  | 137. GRADE    |  | 138. BRANCH   |  |
| 139. DUTY STATION                     |  | 140. DATE     |  | 141. TIME     |  |
| 142. SUBJECT                          |  | 143. ACTION   |  | 144. COMMENTS |  |
| 145. APPROVED                         |  | 146. SIGNED   |  | 147. DATE     |  |
| 148. OFFICE                           |  | 149. DIVISION |  | 150. BRANCH   |  |
| 151. NAME                             |  | 152. GRADE    |  | 153. BRANCH   |  |
| 154. DUTY STATION                     |  | 155. DATE     |  | 156. TIME     |  |
| 157. SUBJECT                          |  | 158. ACTION   |  | 159. COMMENTS |  |
| 160. APPROVED                         |  | 161. SIGNED   |  | 162. DATE     |  |
| 163. OFFICE                           |  | 164. DIVISION |  | 165. BRANCH   |  |
| 166. NAME                             |  | 167. GRADE    |  | 168. BRANCH   |  |
| 169. DUTY STATION                     |  | 170. DATE     |  | 171. TIME     |  |
| 172. SUBJECT                          |  | 173. ACTION   |  | 174. COMMENTS |  |
| 175. APPROVED                         |  | 176. SIGNED   |  | 177. DATE     |  |
| 178. OFFICE                           |  | 179. DIVISION |  | 180. BRANCH   |  |
| 181. NAME                             |  | 182. GRADE    |  | 183. BRANCH   |  |
| 184. DUTY STATION                     |  | 185. DATE     |  | 186. TIME     |  |
| 187. SUBJECT                          |  | 188. ACTION   |  | 189. COMMENTS |  |
| 190. APPROVED                         |  | 191. SIGNED   |  | 192. DATE     |  |
| 193. OFFICE                           |  | 194. DIVISION |  | 195. BRANCH   |  |
| 196. NAME                             |  | 197. GRADE    |  | 198. BRANCH   |  |
| 199. DUTY STATION                     |  | 200. DATE     |  | 201. TIME     |  |
| 202. SUBJECT                          |  | 203. ACTION   |  | 204. COMMENTS |  |
| 205. APPROVED                         |  | 206. SIGNED   |  | 207. DATE     |  |
| 208. OFFICE                           |  | 209. DIVISION |  | 210. BRANCH   |  |
| 211. NAME                             |  | 212. GRADE    |  | 213. BRANCH   |  |
| 214. DUTY STATION                     |  | 215. DATE     |  | 216. TIME     |  |
| 217. SUBJECT                          |  | 218. ACTION   |  | 219. COMMENTS |  |
| 220. APPROVED                         |  | 221. SIGNED   |  | 222. DATE     |  |
| 223. OFFICE                           |  | 224. DIVISION |  | 225. BRANCH   |  |
| 226. NAME                             |  | 227. GRADE    |  | 228. BRANCH   |  |
| 229. DUTY STATION                     |  | 230. DATE     |  | 231. TIME     |  |
| 232. SUBJECT                          |  | 233. ACTION   |  | 234. COMMENTS |  |
| 235. APPROVED                         |  | 236. SIGNED   |  | 237. DATE     |  |
| 238. OFFICE                           |  | 239. DIVISION |  | 240. BRANCH   |  |
| 241. NAME                             |  | 242. GRADE    |  | 243. BRANCH   |  |
| 244. DUTY STATION                     |  | 245. DATE     |  | 246. TIME     |  |
| 247. SUBJECT                          |  | 248. ACTION   |  | 249. COMMENTS |  |
| 250. APPROVED                         |  | 251. SIGNED   |  | 252. DATE     |  |
| 253. OFFICE                           |  | 254. DIVISION |  | 255. BRANCH   |  |
| 256. NAME                             |  | 257. GRADE    |  | 258. BRANCH   |  |
| 259. DUTY STATION                     |  | 260. DATE     |  | 261. TIME     |  |
| 262. SUBJECT                          |  | 263. ACTION   |  | 264. COMMENTS |  |
| 265. APPROVED                         |  | 266. SIGNED   |  | 267. DATE     |  |
| 268. OFFICE                           |  | 269. DIVISION |  | 270. BRANCH   |  |
| 271. NAME                             |  | 272. GRADE    |  | 273. BRANCH   |  |
| 274. DUTY STATION                     |  | 275. DATE     |  | 276. TIME     |  |
| 277. SUBJECT                          |  | 278. ACTION   |  | 279. COMMENTS |  |
| 280. APPROVED                         |  | 281. SIGNED   |  | 282. DATE     |  |
| 283. OFFICE                           |  | 284. DIVISION |  | 285. BRANCH   |  |
| 286. NAME                             |  | 287. GRADE    |  | 288. BRANCH   |  |
| 289. DUTY STATION                     |  | 290. DATE     |  | 291. TIME     |  |
| 292. SUBJECT                          |  | 293. ACTION   |  | 294. COMMENTS |  |
| 295. APPROVED                         |  | 296. SIGNED   |  | 297. DATE     |  |
| 298. OFFICE                           |  | 299. DIVISION |  | 300. BRANCH   |  |
| 301. NAME                             |  | 302. GRADE    |  | 303. BRANCH   |  |
| 304. DUTY STATION                     |  | 305. DATE     |  | 306. TIME     |  |
| 307. SUBJECT                          |  | 308. ACTION   |  | 309. COMMENTS |  |
| 310. APPROVED                         |  | 311. SIGNED   |  | 312. DATE     |  |
| 313. OFFICE                           |  | 314. DIVISION |  | 315. BRANCH   |  |
| 316. NAME                             |  | 317. GRADE    |  | 318. BRANCH   |  |
| 319. DUTY STATION                     |  | 320. DATE     |  | 321. TIME     |  |
| 322. SUBJECT                          |  | 323. ACTION   |  | 324. COMMENTS |  |
| 325. APPROVED                         |  | 326. SIGNED   |  | 327. DATE     |  |
| 328. OFFICE                           |  | 329. DIVISION |  | 330. BRANCH   |  |
| 331. NAME                             |  | 332. GRADE    |  | 333. BRANCH   |  |
| 334. DUTY STATION                     |  | 335. DATE     |  | 336. TIME     |  |
| 337. SUBJECT                          |  | 338. ACTION   |  | 339. COMMENTS |  |
| 340. APPROVED                         |  | 341. SIGNED   |  | 342. DATE     |  |
| 343. OFFICE                           |  | 344. DIVISION |  | 345. BRANCH   |  |
| 346. NAME                             |  | 347. GRADE    |  | 348. BRANCH   |  |
| 349. DUTY STATION                     |  | 350. DATE     |  | 351. TIME     |  |
| 352. SUBJECT                          |  | 353. ACTION   |  | 354. COMMENTS |  |
| 355. APPROVED                         |  | 356. SIGNED   |  | 357. DATE     |  |
| 358. OFFICE                           |  | 359. DIVISION |  | 360. BRANCH   |  |
| 361. NAME                             |  | 362. GRADE    |  | 363. BRANCH   |  |
| 364. DUTY STATION                     |  | 365. DATE     |  | 366. TIME     |  |
| 367. SUBJECT                          |  | 368. ACTION   |  | 369. COMMENTS |  |
| 370. APPROVED                         |  | 371. SIGNED   |  | 372. DATE     |  |
| 373. OFFICE                           |  | 374. DIVISION |  | 375. BRANCH   |  |
| 376. NAME                             |  | 377. GRADE    |  | 378. BRANCH   |  |
| 379. DUTY STATION                     |  | 380. DATE     |  | 381. TIME     |  |
| 382. SUBJECT                          |  | 383. ACTION   |  | 384. COMMENTS |  |
| 385. APPROVED                         |  | 386. SIGNED   |  | 387. DATE     |  |
| 388. OFFICE                           |  | 389. DIVISION |  | 390. BRANCH   |  |
| 391. NAME                             |  | 392. GRADE    |  | 393. BRANCH   |  |
| 394. DUTY STATION                     |  | 395. DATE     |  | 396. TIME     |  |
| 397. SUBJECT                          |  | 398. ACTION   |  | 399. COMMENTS |  |
| 400. APPROVED                         |  | 401. SIGNED   |  | 402. DATE     |  |
| 403. OFFICE                           |  | 404. DIVISION |  | 405. BRANCH   |  |
| 406. NAME                             |  | 407. GRADE    |  | 408. BRANCH   |  |
| 409. DUTY STATION                     |  | 410. DATE     |  | 411. TIME     |  |
| 412. SUBJECT                          |  | 413. ACTION   |  | 414. COMMENTS |  |
| 415. APPROVED                         |  | 416. SIGNED   |  | 417. DATE     |  |
| 418. OFFICE                           |  | 419. DIVISION |  | 420. BRANCH   |  |
| 421. NAME                             |  | 422. GRADE    |  | 423. BRANCH   |  |
| 424. DUTY STATION                     |  | 425. DATE     |  | 426. TIME     |  |
| 427. SUBJECT                          |  | 428. ACTION   |  | 429. COMMENTS |  |
| 430. APPROVED                         |  | 431. SIGNED   |  | 432. DATE     |  |
| 433. OFFICE                           |  | 434. DIVISION |  | 435. BRANCH   |  |
| 436. NAME                             |  | 437. GRADE    |  | 438. BRANCH   |  |
| 439. DUTY STATION                     |  | 440. DATE     |  | 441. TIME     |  |
| 442. SUBJECT                          |  | 443. ACTION   |  | 444. COMMENTS |  |
| 445. APPROVED                         |  | 446. SIGNED   |  | 447. DATE     |  |
| 448. OFFICE                           |  | 449. DIVISION |  | 450. BRANCH   |  |
| 451. NAME                             |  | 452. GRADE    |  | 453. BRANCH   |  |
| 454. DUTY STATION                     |  | 455. DATE     |  | 456. TIME     |  |
| 457. SUBJECT                          |  | 458. ACTION   |  | 459. COMMENTS |  |
| 460. APPROVED                         |  | 461. SIGNED   |  | 462. DATE     |  |
| 463. OFFICE                           |  | 464. DIVISION |  | 465. BRANCH   |  |
| 466. NAME                             |  | 467. GRADE    |  | 468. BRANCH   |  |
| 469. DUTY STATION                     |  | 470. DATE     |  | 471. TIME     |  |
| 472. SUBJECT                          |  | 473. ACTION   |  | 474. COMMENTS |  |
| 475. APPROVED                         |  | 476. SIGNED   |  | 477. DATE     |  |
| 478. OFFICE                           |  | 479. DIVISION |  | 480. BRANCH   |  |
| 481. NAME                             |  | 482. GRADE    |  | 483. BRANCH   |  |
| 484. DUTY STATION                     |  | 485. DATE     |  | 486. TIME     |  |
| 487. SUBJECT                          |  | 488. ACTION   |  | 489. COMMENTS |  |
| 490. APPROVED                         |  | 491. SIGNED   |  | 492. DATE     |  |
| 493. OFFICE                           |  | 494. DIVISION |  | 495. BRANCH   |  |
| 496. NAME                             |  | 497. GRADE    |  | 498. BRANCH   |  |
| 499. DUTY STATION                     |  | 500. DATE     |  | 501. TIME     |  |
| 502. SUBJECT                          |  | 503. ACTION   |  | 504. COMMENTS |  |
| 505. APPROVED                         |  | 506. SIGNED   |  | 507. DATE     |  |
| 508. OFFICE                           |  | 509. DIVISION |  | 510. BRANCH   |  |
| 511. NAME                             |  | 512. GRADE    |  | 513. BRANCH   |  |
| 514. DUTY STATION                     |  | 515. DATE     |  | 516. TIME     |  |
| 517. SUBJECT                          |  | 518. ACTION   |  | 519. COMMENTS |  |
| 520. APPROVED                         |  | 521. SIGNED   |  | 522. DATE     |  |
| 523. OFFICE                           |  | 524. DIVISION |  | 525. BRANCH   |  |
| 526. NAME                             |  | 527. GRADE    |  | 528. BRANCH   |  |
| 529. DUTY STATION                     |  | 530. DATE     |  | 531. TIME     |  |
| 532. SUBJECT                          |  | 533. ACTION   |  | 534. COMMENTS |  |
| 535. APPROVED                         |  | 536. SIGNED   |  | 537. DATE     |  |
| 538. OFFICE                           |  | 539. DIVISION |  | 540. BRANCH   |  |
| 541. NAME                             |  | 542. GRADE    |  | 543. BRANCH   |  |
| 544. DUTY STATION                     |  | 545. DATE     |  | 546. TIME     |  |
| 547. SUBJECT                          |  | 548. ACTION   |  | 549. COMMENTS |  |
| 550. APPROVED                         |  | 551. SIGNED   |  | 552. DATE     |  |
| 553. OFFICE                           |  | 554. DIVISION |  | 555. BRANCH   |  |
| 556. NAME                             |  | 557. GRADE    |  | 558. BRANCH   |  |
| 559. DUTY STATION                     |  | 560. DATE     |  | 561. TIME     |  |
| 562. SUBJECT                          |  | 563. ACTION   |  | 564. COMMENTS |  |
| 565. APPROVED                         |  | 566. SIGNED   |  | 567. DATE     |  |
| 568. OFFICE                           |  | 569. DIVISION |  | 570. BRANCH   |  |
| 571. NAME                             |  | 572. GRADE    |  | 573. BRANCH   |  |
| 574. DUTY STATION                     |  | 575. DATE     |  | 576. TIME     |  |
| 577. SUBJECT                          |  | 578. ACTION   |  | 579. COMMENTS |  |
| 580. APPROVED                         |  | 581. SIGNED   |  | 582. DATE     |  |
| 583. OFFICE                           |  | 584. DIVISION |  | 585. BRANCH   |  |
| 586. NAME                             |  | 587. GRADE    |  | 588. BRANCH   |  |
| 589. DUTY STATION                     |  | 590. DATE     |  | 591. TIME     |  |
| 592. SUBJECT                          |  | 593. ACTION   |  | 594. COMMENTS |  |
| 595. APPROVED                         |  | 596. SIGNED   |  | 597. DATE     |  |
| 598. OFFICE                           |  | 599. DIVISION |  | 600. BRANCH   |  |
| 601. NAME                             |  | 602. GRADE    |  | 603. BRANCH   |  |
| 604. DUTY STATION                     |  | 605. DATE     |  | 606. TIME     |  |
| 607. SUBJECT                          |  | 608. ACTION   |  | 609. COMMENTS |  |
| 610. APPROVED                         |  | 611. SIGNED   |  | 612. DATE     |  |
| 613. OFFICE                           |  | 614. DIVISION |  | 615. BRANCH   |  |
| 616. NAME                             |  | 617. GRADE    |  | 618. BRANCH   |  |
| 619. DUTY STATION                     |  | 620. DATE     |  | 621. TIME     |  |
| 622. SUBJECT                          |  | 623. ACTION   |  | 624. COMMENTS |  |
| 625. APPROVED                         |  | 626. SIGNED   |  | 627. DATE     |  |
| 628. OFFICE                           |  | 629. DIVISION |  | 630. BRANCH   |  |
| 631. NAME                             |  | 632. GRADE    |  | 633. BRANCH   |  |
| 634. DUTY STATION                     |  | 635. DATE     |  | 636. TIME     |  |
| 637. SUBJECT                          |  | 638. ACTION   |  | 639. COMMENTS |  |
| 640. APPROVED                         |  | 641. SIGNED   |  | 642. DATE     |  |
| 643. OFFICE                           |  | 644. DIVISION |  | 645. BRANCH   |  |
| 646. NAME                             |  | 647. GRADE    |  | 648. BRANCH   |  |
| 649. DUTY STATION                     |  | 650. DATE     |  | 651. TIME     |  |
| 652. SUBJECT                          |  | 653. ACTION   |  | 654. COMMENTS |  |
| 655. APPROVED                         |  | 656. SIGNED   |  | 657. DATE     |  |
| 658. OFFICE                           |  | 659. DIVISION |  | 660. BRANCH   |  |
| 661. NAME                             |  | 662. GRADE    |  | 663. BRANCH   |  |
| 664. DUTY STATION                     |  | 665. DATE     |  | 666. TIME     |  |
| 667. SUBJECT                          |  | 668. ACTION   |  | 669. COMMENTS |  |
| 670. APPROVED                         |  | 671. SIGNED   |  | 672. DATE     |  |
| 673. OFFICE                           |  | 674. DIVISION |  | 675. BRANCH   |  |
| 676. NAME                             |  | 677. GRADE    |  | 678. BRANCH   |  |
| 679. DUTY STATION                     |  | 680. DATE     |  | 681. TIME     |  |
| 682. SUBJECT                          |  | 683. ACTION   |  | 684. COMMENTS |  |
| 685. APPROVED                         |  | 686. SIGNED   |  | 687. DATE     |  |
| 688. OFFICE                           |  | 689. DIVISION |  | 690. BRANCH   |  |
| 691. NAME                             |  | 692. GRADE    |  | 693. BRANCH   |  |
| 694. DUTY STATION                     |  | 695. DATE     |  | 696. TIME     |  |
| 697. SUBJECT                          |  | 698. ACTION   |  | 699. COMMENTS |  |
| 700. APPROVED                         |  | 701. SIGNED   |  | 702. DATE     |  |
| 703. OFFICE                           |  | 704. DIVISION |  | 705. BRANCH   |  |
| 706. NAME                             |  | 707. GRADE    |  | 708. BRANCH   |  |
| 709. DUTY STATION                     |  | 710. DATE     |  | 711. TIME     |  |
| 712. SUBJECT                          |  | 713. ACTION   |  | 714. COMMENTS |  |
| 715. APPROVED                         |  | 716. SIGNED   |  | 717. DATE     |  |
| 718. OFFICE                           |  | 719. DIVISION |  | 720. BRANCH   |  |
| 721. NAME                             |  | 722. GRADE    |  | 723. BRANCH   |  |
| 724. DUTY STATION                     |  | 725. DATE     |  | 726. TIME     |  |
| 727. SUBJECT                          |  | 728. ACTION   |  | 729. COMMENTS |  |
| 730. APPROVED                         |  | 731. SIGNED   |  | 732. DATE     |  |
| 733. OFFICE                           |  | 734. DIVISION |  | 735. BRANCH   |  |
| 736. NAME                             |  | 737. GRADE    |  | 738. BRANCH   |  |
| 739. DUTY STATION                     |  | 740. DATE     |  | 741. TIME     |  |
| 742. SUBJECT                          |  | 743. ACTION   |  | 744. COMMENTS |  |
| 745. APPROVED                         |  | 746. SIGNED   |  | 747. DATE     |  |
| 748. OFFICE                           |  | 749. DIVISION |  | 750. BRANCH   |  |
| 751. NAME                             |  | 752. GRADE    |  | 753. BRANCH   |  |
| 754. DUTY STATION                     |  | 755. DATE     |  | 756. TIME     |  |
| 757. SUBJECT                          |  | 758. ACTION   |  | 759. COMMENTS |  |
| 760. APPROVED                         |  | 761. SIGNED   |  | 762. DATE     |  |
| 763. OFFICE                           |  | 764. DIVISION |  | 765. BRANCH   |  |
| 766. NAME                             |  | 767. GRADE    |  | 768. BRANCH   |  |
| 769. DUTY STATION                     |  | 770. DATE     |  | 771. TIME     |  |
| 772. SUBJECT                          |  | 773. ACTION   |  | 774. COMMENTS |  |
| 775. APPROVED                         |  | 776. SIGNED   |  | 777. DATE     |  |
| 778. OFFICE                           |  | 779. DIVISION |  | 780. BRANCH   |  |
| 781. NAME                             |  | 782. GRADE    |  | 783. BRANCH   |  |
| 784. DUTY STATION                     |  | 785. DATE     |  | 786. TIME     |  |
| 787. SUBJECT                          |  | 788. ACTION   |  | 789. COMMENTS |  |
| 790. APPROVED                         |  | 791. SIGNED   |  | 792. DATE     |  |
| 793. OFFICE                           |  | 794. DIVISION |  | 795. BRANCH   |  |
| 796. NAME                             |  | 797. GRADE    |  | 798. BRANCH   |  |
| 799. DUTY STATION                     |  | 800. DATE     |  | 801. TIME     |  |
| 802. SUBJECT                          |  | 803. ACTION   |  | 804. COMMENTS |  |
| 805. APPROVED                         |  | 806. SIGNED   |  | 807. DATE     |  |
| 808. OFFICE                           |  | 809. DIVISION |  | 810. BRANCH   |  |
| 811. NAME                             |  | 812. GRADE    |  | 813. BRANCH   |  |
| 814. DUTY STATION                     |  | 815. DATE     |  | 816. TIME     |  |
| 817. SUBJECT                          |  | 818. ACTION   |  | 819           |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 8002051 |  |
|--|--|--|--|--|--|--|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Wilma Worthley Johnson  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 10 80  |  | 2b. HOUR<br>0307 M   |  |                  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>June 12 1914   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  | 7a. IF UNDER 1 YEAR MONTHS DAYS<br>7b. IF UNDER 24 HRS. HOURS MIN  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.  |  |  |  |                  |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventis Hosp. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>home  |  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>746 Clopper Road #23  |  |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Jerimiah H. Worthley  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Jettie   |  |  |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |  |  | 16b. SOCIAL SECURITY NO<br>411 28 5069   |  | 17 INFORMANT ADDRESS<br>Robert L. Johnson same as 13e  |  |  |  |                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Intractable Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) ~ 20 years                   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days   |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Severe Systemic Rheumatoid Arthritis   |  |  |  |  |  |  |  |  |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 9 19 80 to JAN. 10 19 80, that (I) (we) last saw the deceased alive on JAN. 10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                  |  |
| 22b. SIGNATURE James E. Wilson M.D.  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/10/80  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES E. WILSON, Jr. M.D.   |  |  |  | 22e. ADDRESS<br>11125 Rockville Pike, Rockville, Md. 20852   |  |  |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/12/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland   |  |  |  |                  |  |
| 24 FUNERAL DIRECTOR'S NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland 20852  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>A. J. McCreedy   |  |  |  |                  |  |



James H. ...  
Tennessee ...

700 ...  
X ...  
Tennessee ...  
411 ...

...

...

...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02052

|   |         |  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|--------------------------------------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY                                  |  | YEAR |  | 2b. HOUR  |  |
| Francis Lee Jones   |         |  |  |   |  |   |  | JAN 4 1980                                   |  |                          |  |                                      |  |      |  | 8:00 P.M. |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH                                |  | DAY  |  | YEAR      |  |
| M   | W       | May 15 26  |  | 53 YRS.   |  |   |  |  |  | JAN 4 1980               |  |                                      |  |      |  | 8:00 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED                                      |  | DIVORCED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |      |  |           |  |
| MARYLAND  |         | U.S.A.   |  | <input checked="" type="checkbox"/>   |  | <input type="checkbox"/>  |  | <input type="checkbox"/>                     |  | <input type="checkbox"/> |  | Montgomery                           |  |      |  | MD.       |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |                                      |  |      |  |           |  |
| Tak Park  |         | Wash. Advent. Hosp   |  | BINDER  |  | VITRO LAB.  |  |  |  |                          |  |                                      |  |      |  |           |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |                                      |  |      |  |           |  |
| Md  |         | Prince Georges   |  | Alaphi  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2031 New Riggs Rd                            |  |                          |  |                                      |  |      |  |           |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  | ADDRESS                  |  |                                      |  |      |  |           |  |
| CHARLES JONES   |         | SARAH QUINN  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 215-20-5228   |  | PATRICIA CAROL JONES                         |  | SAME AS 13 WIFE          |  |                                      |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |                                      |  |      |  |           |  |
| 4391  |         | Acute myocardial Dis   |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
|   |         |  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |                                      |  |      |  |           |  |
|   |         |  |  | (c)   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         | None   |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |                                      |  |      |  |           |  |
| None  |         |  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
|   |         | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | STREET  |  | CITY OR TOWN                                 |  | COUNTY                   |  | STATE                                |  |      |  |           |  |
|   |         |  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |  | MEDICAL EXAMINER  |  | DATE SIGNED   |  |  |  |                          |  |                                      |  |      |  |           |  |
| John S. Rogers  |         | M.D.   |  | JAN 4 1980  |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| JOHN S. ROGERS  |         | 1919 SEMINARY ROAD, SILVER SPRING, MD.   |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | CITY OR TOWN                                 |  | COUNTY                   |  | STATE                                |  |      |  |           |  |
| BURIAL  |         | 1/8/80   |  | GATE OF HEAVEN  |  | SILVER SPRING   |  |  |  | MONT                     |  | MD.                                  |  |      |  |           |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| FRANCIS J. COLLINS  |         | JAN 9 1980   |  | [Signature]   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| NAME  |         | ADDRESS  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |         |  |  |   |  |   |  |  |  |                          |  |                                      |  |      |  |           |  |

A.2.4

02402414

PAUL J. HARRIS, JR.

202-98-217

Figure 1

02/2/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

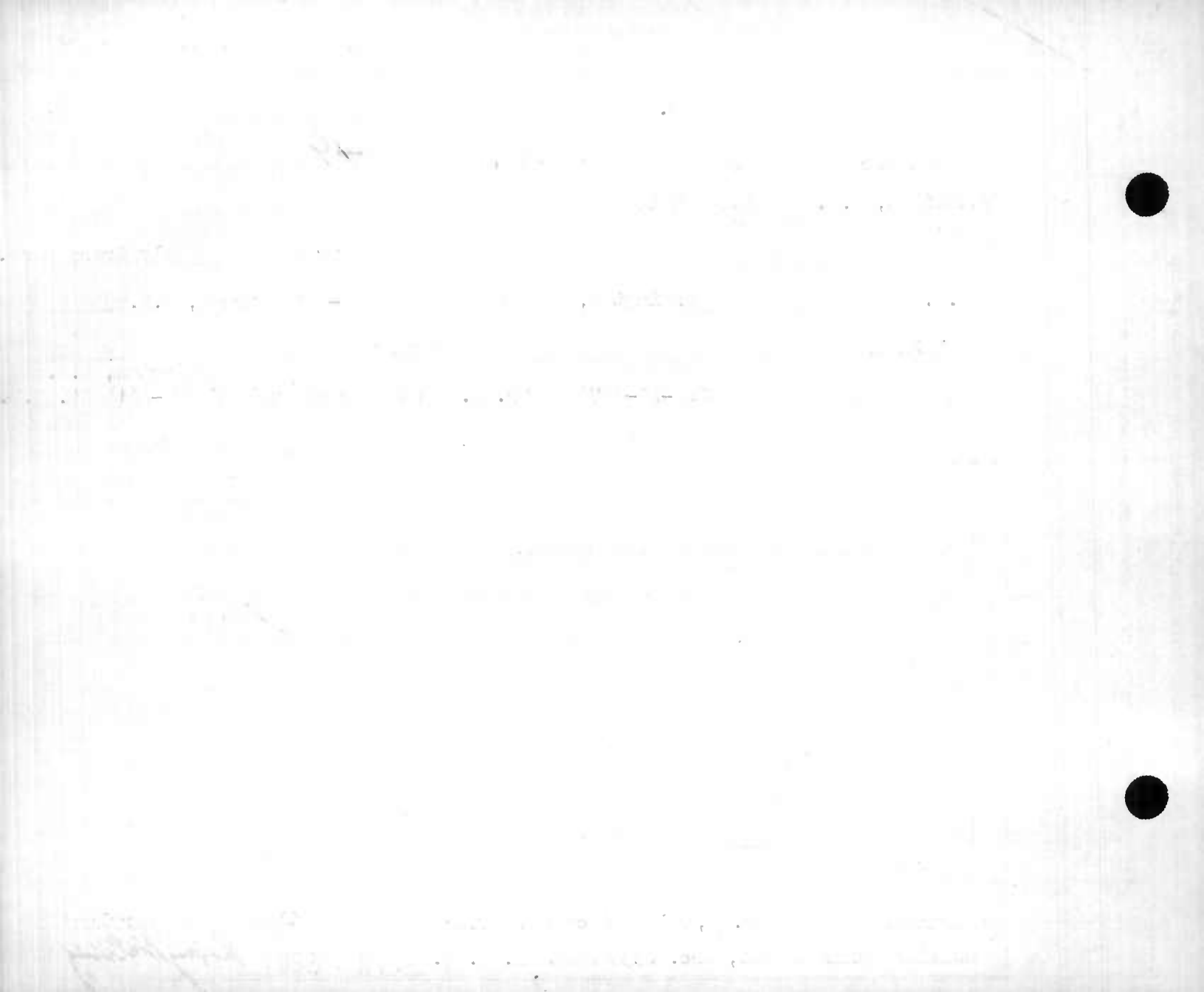
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002053

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN W. JORDAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 3 80</b> |   |  | 2b. HOUR<br><b>12 45 AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20, 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>49</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Greenville, S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Holy Cross Hosp.</b>   |  |
| 13a. STATE<br><b>D.C.</b>  |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>800-46th Street, N.E.</b>                                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>249-42-5876</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Washington, D.C.</b><br><b>Mr. F. Mason Jordan/Husband/800-46th St. N.E.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - brain stem area</b><br><b>4340</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>52 hours</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>arterial hypertension</b>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1980</b> to <b>January 3, 1980</b> , that (I) (we) last saw the deceased alive on <b>January 2, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Aaron H. Traum MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>January 3 '80</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aaron H. Traum MD</b>  |  |  |  | 22d. ADDRESS<br><b>8915 Georgia Ave Silver Spring Maryland</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 8, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG Maryland</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Rollins Funeral Home, Inc.</b>  |  |  |  | ADDRESS<br><b>4339 Hunt Pl. N. E.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1980</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |



TO HOSPITAL - ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002054

REG. NO.

|  |  |  |   |  |                                   |  |  |
|--|--|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | MONTH DAY YEAR   |                                   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | MONTH DAY YEAR   |                                   | 2b. HOUR   |  |
| Rose D'Lat Kartoffel   |  | JANUARY 14, 1980   |   |  |                                   | 7:30 PM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |  |
| Female   | White  | JAN. 31, 1893  | 86  | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |  |  |
| RUSSIA   | U. S. A.   |  | MONTGOMERY MD.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| TAKOMA PARK  | WASHINGTON ADVENTIST HOSPITAL  |  | HOUSEWIFE   |  | OWN HOME                          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |                                   |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |  |  |
| MARYLAND   | PR. GEORGES  | HYATTSVILLE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3704 GALLATIN STREET   |                                   |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |  |  |
| Avrum D'Lat  |  | Not Ascertainable  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |  |  |
| NO   |  | 578-38-4441-J1   |   | 3708 JEFFERSON STREET, HERSH D. MILLER, HYATTSVILLE, MARYLAND  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) C.V.A.   |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis  |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |   | 21f. LOCATION  |                                   |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 28, 1979 to Jan 14, 1980, that (I) (we) last saw the deceased alive on Jan 14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED   |  |
| Boris RABICIN  |  |  |   |  |                                   | 1-15-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |  |  |
| Boris RABICIN  |  | 1079 Univ. Blvd. East  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION  |  |
| BURIAL   |  | 1/17/1980  |   | KESHER ISRAEL CONGREGATION CEMETERY  |                                   | HILLSIDE, PR. GEO. MD.   |  |
| 24. FUNERAL DIRECTOR'S NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| DENALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |  | JAN 21 1980  |   | [Signature]  |                                   |  |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C.  |  |  |   |  |                                   |  |  |

TO HOSPITAL - ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





029

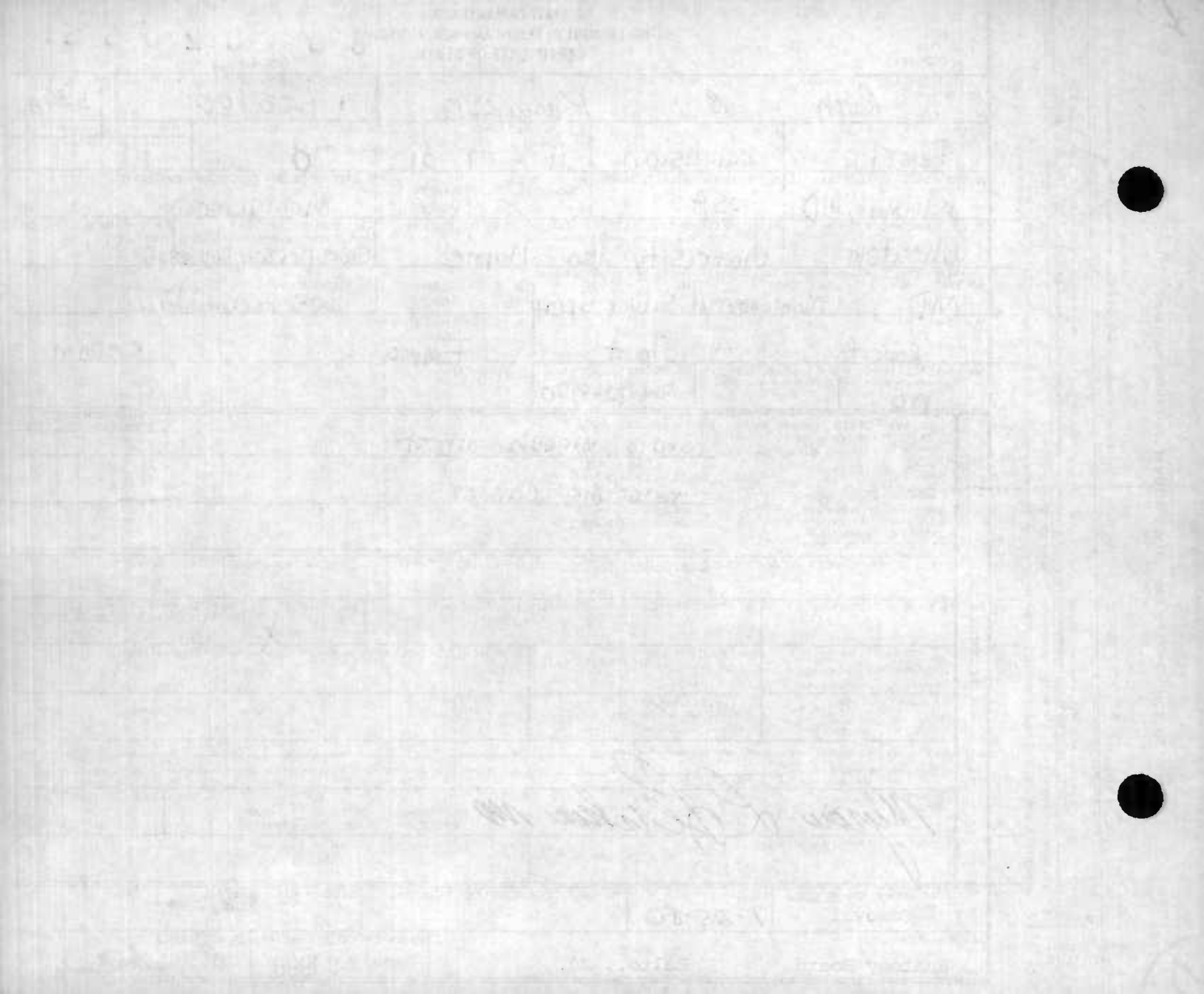


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |   |   | REG. NO. 002055   |  |                             |  |  |  |
|---|--|--|---|---|--|--|--|---|---|---|--|-----------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR  |  |                             |  | 2b. HOUR                               |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth B. Kasaczun   |  |  |   |   |  |  |  |   |   | 1/25/80   |  |                             |  | 5:30 A.M.                              |  |
| 3. SEX Female   |  |  | 4. RACE caucasian   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 29 01   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.             |   |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD   |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. |   |  |                             |  |  |  |
| 10. CITY OR TOWN OF DEATH Wheaton   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Aca. Home |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson, housewife   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |   |  |                             |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |  |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |                             |  | 13e. STREET ADDRESS 11603 Bucknell Dr. |  |
| 13a. STATE MD   |  |  | 13b. COUNTY Montgomery  |   |  | 13c. CITY OR TOWN Silver Spring  |  |   |   |   |  |                             |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Sinnott  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Kellum |  |  |   |   |   |  |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |  |   |   | 16b. SOCIAL SECURITY NO. 214-12-8170                   |  |  |   |   | 17. INFORMANT ADDRESS   |  |                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio-vascular arrest<br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) metastatic cancer<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                             |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |  |   |   |   |  |                             |  |  |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |                             |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____ above, (I) (we) (did) (did not) view the body after death _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |   |   |  |  |  |   |   |   |  |                             |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thynon L. L. L. M.D.  |  |  |   |   |  |  |  |   |   | 22c. DATE SIGNED  |  |                             |  |  |  |
| 22d. ADDRESS  |  |  |   |   |  |  |  |   |   | 22e. DATE REC'D. BY REGISTRAR 1 JAN 29 1980   |  |                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal   |  |  |   | 23b. DATE 1-25-80   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                             |  |  |  |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.   |  |  |   |   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR 1 JAN 29 1980   |  |                             |  | 25b. REGISTRAR'S SIGNATURE             |  |





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 5 6  
REG. NO.

|   |  |   |  |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Herman NMN Katz</i> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1-21-80</i>                        |  | 2b. HOUR<br><i>11:45 PM</i>  |  |   |  |  |  |
| 3 SEX<br><i>Male</i>  |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2-14-09</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Russia</i>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>America</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                               |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Takoma Park</i>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Purchasing Mgr.</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Private Club</i>           |  |  |
| 13a. STATE<br><i>Md.</i>  |  |   | 13b. COUNTY<br><i>Mont.</i>  |  | 13c. CITY OR TOWN<br><i>Silver Spring</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>14508 Homecrest Road</i> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>David Katz</i>                        |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Fannie (unknown)</i>      |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i> |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>578-20-8886</i> |  | 17 INFORMANT<br>ADDRESS<br><i>Lee Drapkin; 717 Burnt Mills Ct., Sil Spg, Md.</i> |  |   |  |  |  |

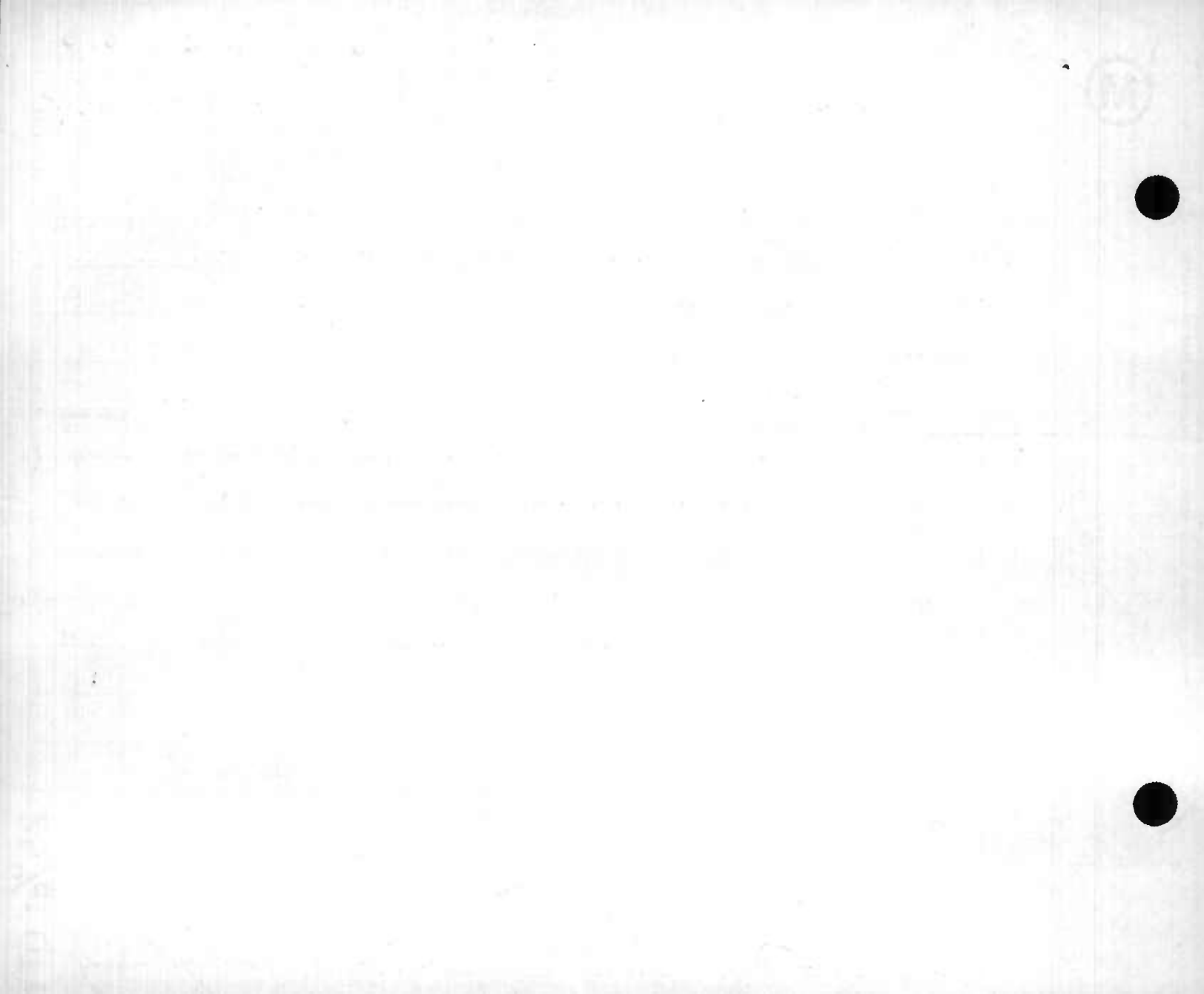
|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Malastatic (Hepatic) Capillary</i><br><i>1539</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cancerous (25) of Colon</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Yrs</i> |
|--|--|--|

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>11/19/79</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Esophageal obstruction</i> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>11/12/79</i> , 19 <i>79</i> , to <i>1/21/80</i> , 19 <i>80</i> , that (i) (we) last saw the deceased alive on <i>1/21/80</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>HL. MARTER</i>  |  |   |  | DEGREE<br><i>MD</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1/21/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS<br><i>831 University Blvd, S, 55</i>   |  |   |  |

|  |  |                               |  |   |  |   |  |   |  |
|--|--|-------------------------------|--|---|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                             |  | 23b. DATE<br><i>1-24-1980</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>D. C. Lodge Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Washington, D.C.</i> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i> |  |                               |  | ADDRESS<br><i>Rockville, Md.</i>                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 28 1980</i>                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>L. J. McCreedy</i> |  |

1- The low requires that the death certificate be executed within 24 hours after death. Page 4 must be returned to the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 must be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8002057  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) Charles Mathias KELLY  |  |   |  | January 1, 1980   |  |  |  | 7:10a   |  |
| 3 SEX Male  |  | 4 RACE Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR October 16, 1923   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine  |  | 7b CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD                             |  |   |  |
| 10 CITY OR TOWN OF DEATH Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION National Naval Medical Center |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Navy & Civil Service |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE Maryland  |  |   |  | 13b COUNTY Charles  |  | 13c CITY OR TOWN Indian Head   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Earl Lloyd Kelly   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Victoria Lenore Mathias   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN Yes   |  |   |  | 16b SOCIAL SECURITY NO. 1942-1962   |  | 17 INFORMANT ADDRESS Falmouth, Va. Cynthia White Wolf, 900 Anderson Dr.              |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1919 Glioblastoma Multiforme  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)  |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)  |  |   |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  |   |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22 I certify that (a) (this hospital) attended the deceased from September 16, 79 to Jan 01 19 80, that (b) (we) lost show the deceased alive on Jan 01 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22a SIGNATURE W.S. FISHER M.D.  |  |   |  | DEGREE  |  |  |  | 22c DATE SIGNED Jan. 1, 1980  |  |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT) W.S. FISHER M.D.   |  |   |  | 22e ADDRESS NNMC, Bethesda, Md. 20014   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL Burial   |  | 23b DATE 1-4-80   |  | 23c NAME OF CEMETERY OR CREMATORY St. Mark's Cem.   |  | 23d LOCATION CITY OR TOWN COUNTY STATE Perryville, Md.                               |  |   |  |
| 24 FUNERAL DIRECTOR NAME Huntt's Funeral Home   |  |   |  | ADDRESS Waldorf, Md.  |  | 25a DATE REC'D. BY REGISTRAR JAN 8 1980  |  | 25b REGISTRAR'S SIGNATURE   |  |

Name: Barbara Female Canadian October 16, 1922 55 January 1, 1950 7:10a  
 Address: U.S.A. Ordinary Country  
 Occupation: National Navy Medical Center Civil Service  
 Remarks: Box 164 Indian Head Maryland Charles Indian Head Box 164 Indian Head Maryland  
 Date: 1943-1967 215-16-10350 synthesis Wittmeyer 900 Anderson Dr. Falmouth, Va. May Victoria Lenore Nathans  
 Signature: Glenn Wittmeyer

Date: September 11, 79 Jan 61 80  
 Address: St. Mark's am. Terryville Md.  
 Remarks: Wittmeyer 900 Anderson Dr. Falmouth, Va. May Victoria Lenore Nathans  
 Date: Jan 1, 1980



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |  |  |   |  |   |   | REG. NO. 02058  |  |
|--|--|---------------------|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>M. Idres M Kendrick</i>  |  |                     |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><i>Jan 4 1980</i>  |  | 2b. HOUR<br><i>2:00</i>   |   |   |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>W</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Feb. 18 1897</i>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><i>82 YRS.</i>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><i>Jan 4 1980</i>                   |   | 7b. HOUR<br><i>2:00</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington DC</i>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery MD</i>                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Tak Park</i>   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Ignace Gardens NH</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>--</i>                                      |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD</i> 13b. COUNTY <i>Prince George's</i> 13c. CITY OR TOWN <i>Hillcrest</i>   |  |                     |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>4004 21st Pl</i>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John T. Ward</i>  |  |                     |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bertha Cole</i>   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>   |  |                     |  | 16b. SOCIAL SECURITY NO.<br><i>579 68 0161</i>   |  | 17. INFORMANT<br><i>Son</i>   |  |   | ADDRESS<br><i>Same as #13</i>                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Bronchial Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>1 day</i>   |  |                     |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i>                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>Fracture L. hip</i>  |  |                     |  |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><i>7-22-79</i>   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><i>Fracture L. hip</i>  |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><i>CA 9-21-1979</i>  |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>PM 9 21 1979</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><i>Fall on floor</i>   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><i>N.H.</i>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>Crown Hill Ave, Tak Park Mont Md</i>  |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |  |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Robert E. Wilhelm</i>   |  |                     |  |  |  | TITLE (SPECIFY)<br><i>MD</i>  |  |   | MEDICAL EXAMINER<br><i>Cap</i>                  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>Robert E. Wilhelm</i>   |  |                     |  |  |  | ADDRESS<br><i>Funeral Home Inc</i>  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |                     |  | 23b. DATE<br><i>7Jan1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland PG Maryland</i>           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Robert E. Wilhelm</i>   |  |                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 8 1980</i>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Montgomery</i> |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH        |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7. DATE OF BIRTH   |  | 8. AGE (IN YEARS LAST BIRTHDAY)             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  | 10. CITY OR TOWN OF DEATH                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2. DATE OF DEATH   |  | 3. SEX                                      |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |
| JEAN  |  | JANUARY 22 1980  |  | FEMALE                                      |  | WHITE   |  | AUGUST 28, 1905   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH        |  | 10. CITY OR TOWN OF DEATH                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION       |  |
| PENNSYLVANIA  |  |  |  | MONTGOMERY                                  |  | SILVER SPRING   |  | 8802 SUNDALE DRIVE  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13. INSIDE CITY LIMITS?  |  | 14. FATHER'S NAME                           |  | 15. MOTHER'S MAIDEN NAME                                      |  | 16. SOCIAL SECURITY NO.                                       |  |
| MARYLAND MONTGOMERY SILVER SPRING   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | JACOB KATZ                                  |  | ANNA (UNASCERTAINABLE)  |  | 579-20-5059   |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | 19. DATE OF OPERATION                       |  | 20. AUTOPSY?  |  | 21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| NORMAN KERTZMAN, same as #13  |  | PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> |  | 20. DATE OF OPERATION                       |  | 21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 22. DATE SIGNED   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 24. FUND   |  | 25. DATE REC'D. BY REGISTRAR                |  | 26. REGISTRAR'S SIGNATURE                                     |  | 27. DATE SIGNED   |  |
| BURIAL  |  | 1/24/1980  |  | JAN 25 1980                                 |  | Rickey McCreedy   |  | Jan 22 1980   |  |
| 28. NAME OF CEMETERY OR CREMATORY   |  | 29. LOCATION   |  | 30. COUNTY                                  |  | 31. STATE   |  | 32. NAME OF CEMETERY OR CREMATORY                             |  |
| JUDAN MEMORIAL GARDENS  |  | OLNEY  |  | MONTGOMERY                                  |  | MARYLAND  |  | JUDAN MEMORIAL GARDENS  |  |
| 33. NAME OF CEMETERY OR CREMATORY   |  | 34. LOCATION   |  | 35. COUNTY                                  |  | 36. STATE   |  | 37. NAME OF CEMETERY OR CREMATORY                             |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C.   |  | 232 CARROLL STREET, N.W., WASHINGTON, D. C.  |  | 232 CARROLL STREET, N.W., WASHINGTON, D. C. |  | 232 CARROLL STREET, N.W., WASHINGTON, D. C.                   |  | 232 CARROLL STREET, N.W., WASHINGTON, D. C.                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMM-16 25M  
(VRA 15, 4) 1/79

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |  |  |  |   |  |
| REG. NO. 8002060   |  |   |  |  |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Blayne C Key SAR  |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>1-25-80   |  |  | 2b HOUR<br>1A M   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>3 26, 1925   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS   |  | 7a IF UNDER 1 YEAR MONTHS DAYS<br>7b IF UNDER 24 HRS HOURS MIN  |  |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Hampshire  |  | 7d CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co., MD.                         |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Eng. Tech., Bureau |  | 12b KIND OF BUSINESS OR INDUSTRY<br>of Standards  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  | 13a INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13b STREET ADDRESS<br>Rt. 1, Box 597, Overlook Dr. |   |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Frederick   |  | 13c CITY OR TOWN<br>Monrovia   |  |  |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Clyde W. Keysar  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eva E. Marsh                                      |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO<br>578-58-8174   |  | 17 INFORMANT ADDRESS<br>Opal M. Keysar, Item 13  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u>  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>45 min  |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute pulmonary edema</u>   |  |   |  |  |  |  |  | 1 hr  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u>   |  |   |  |  |  |  |  | 3 wks   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 1-7, 19 80, to 1-25, 19 80, that (I) (we) lost<br>saw the deceased alive on 1-24, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br>Thomas G. Sinderson, MD   |  |   |  |  |  |  |  | 22c DATE SIGNED<br>1-25-80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS G. SINDERSON, MD  |  |   |  |  | 22e ADDRESS<br>11125 ROCKVILLE PIKE, ROCKVILLE, Md. 20852                                      |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>Jan. 28, 1980   |  | 23c NAME OF CEMETERY OR CREMATORY<br>National Mem. Park  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia                   |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Olin L. Molesworth, Damascus, Md.  |  |   |  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 29 1980  |  | 25b REGISTRAR'S SIGNATURE<br>Lester McCreedy       |   |  |





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |   | REG. NO. 3002061 |  |
|--|--|---|--|---|---|--|--|--|---|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE KIRSCH</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11/11/80</b>   |  |  | 2b. HOUR<br><b>11:40</b> M   |   |                  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 6 99</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                            |  |  |   |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>WHEATON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Randolph Hills Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher (Ret)</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Schools</b>                                  |   |                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>10113 GRAVIER COURT</b>                  |  |   |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EOEL BASNICK</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hannah Novich</b>                           |  |  |  |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>146-28-7456</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>M. Nieboeller BHHH</b>              |  |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer respiratory tract</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>lean</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>stroke</b> <b>hypertension</b>   |  |   |  |   |   |  |  |  |   |                  |  |
| 19a. DATE OF OPERATION   |  |   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |   |  |  |  |   |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                               |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |                  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>November 16, 1980</b> to <b>January 11, 1980</b> , that (1) (we) lost saw the deceased alive on <b>January 11, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |  |  |   |                  |  |
| 22b. SIGNATURE<br><b>Bernard H. Krumm, M.D.</b>  |  |   |  |   | DEGREE<br><b>M.D.</b>   |  |  | 22c. DATE SIGNED<br><b>1-11-80</b>   |   |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard H. Krumm, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>3720 Fairview Ave. Kow. Md. 20757</b>  |  |  |  |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  |   | 23b. DATE<br><b>1-13-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>B'nai Israel Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Newark, New Jersey</b> |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>   |  |   |  |   | ADDRESS<br><b>Rockville, Md.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1980</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |                  |  |



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20 X 30 cm

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

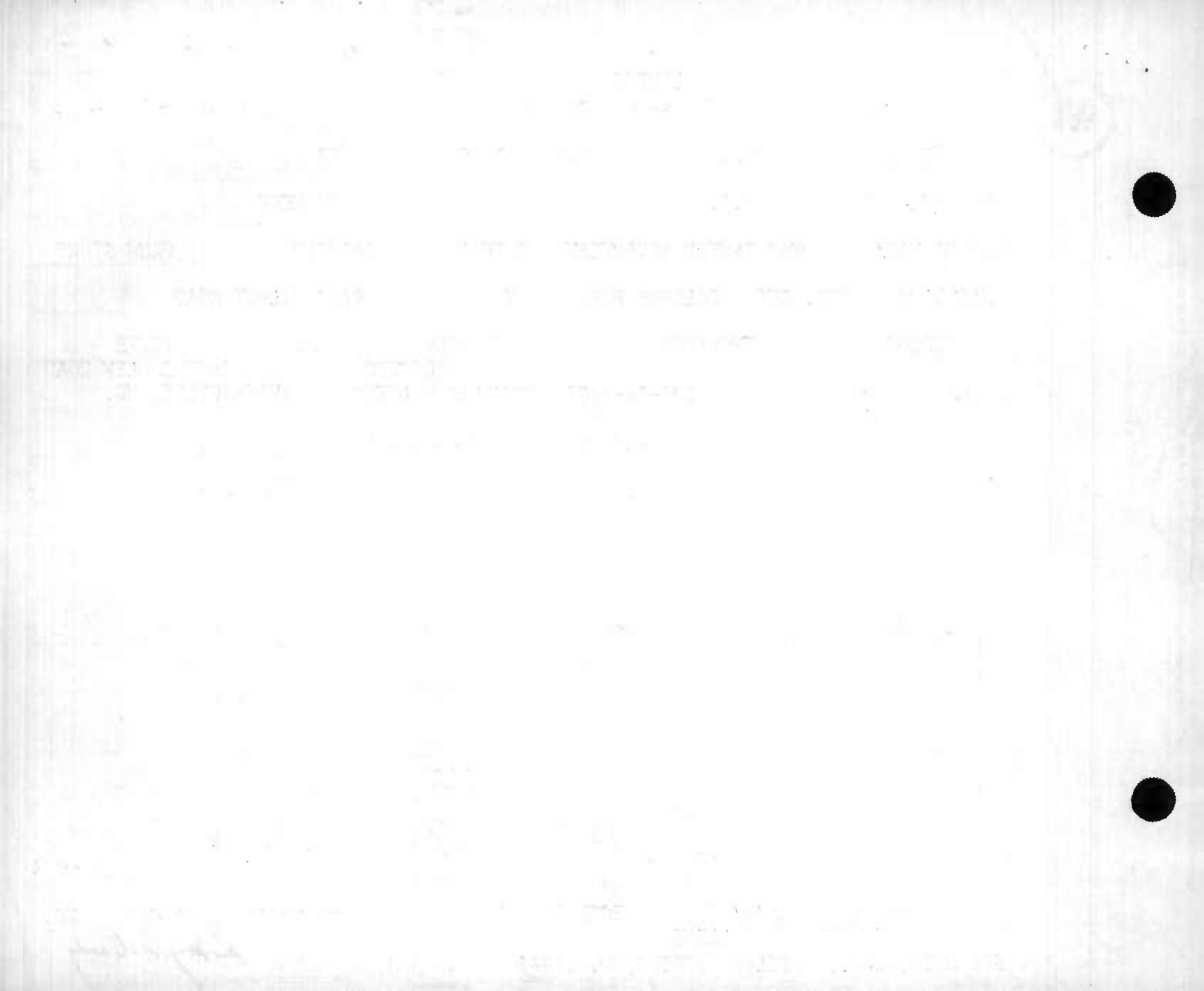
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002062

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elizabeth L. KLine</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-6-80</b> |   |  | 2b. HOUR<br><b>4 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 9, 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CASHIER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRUG STORE</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>PRI. GEO</b>   |  | 13c. CITY OR TOWN<br><b>COLLEGE PARK</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE THOMPSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FRANCES A. PITTS</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>209-16-6073</b>   |  | 17. INFORMANT<br><b>DAUGHTER</b>  |  | ADDRESS<br><b>6800 CONLEY ROAD<br/>HYATTSVILLE, MD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4415</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RENAL FAILURE &amp; PULMONARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>INSUFFICIENCY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>&amp; HEPATIC FAILURE</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/17/1979</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LEAKING AORTIC ANEURYSM</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>S. NEIMAT, MD.</b>   |  | DEGREE<br><b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. NEIMAT, MD.</b>  |  | 22e. ADDRESS<br><b>881 UNIVERSITY BLVD. E.<br/>SILVER SPRING, MD. 20903</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/9/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BRENTWOOD PRI GEO MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b><br>ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |



#2a, 22a, Film G540 2/11/80 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

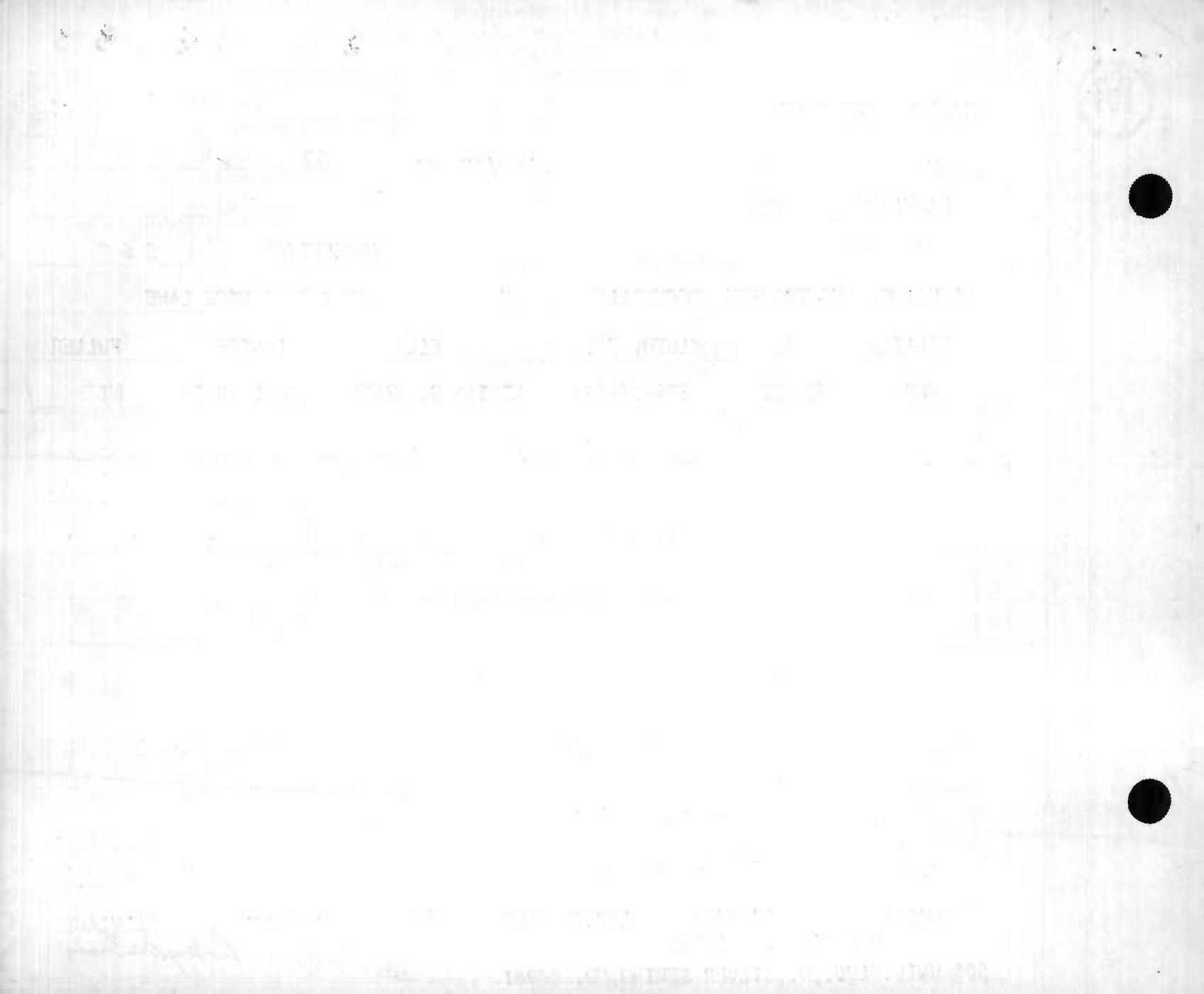
8 0 0 2 0 6 3

REG. NO.

|  |              |  |  |   |  |
|--|--------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILMER <del>XXXXXXXXXX</del> C. Kluth   |              | 2a. DATE OF DEATH<br>MONTH 1 DAY 12 YEAR 80  |  | 2b. HOUR<br>3 P. M.   |  |
| 3. SEX<br>M  | 4. RACE<br>W | 5. DATE OF BIRTH<br>MONTH 2 DAY 10 YEAR 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR   |              | 12b. KIND OF BUSINESS OR INDUSTRY<br>C & P   |  |   |  |
| 13a. STATE<br>MARYLAND   |              | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>ROCKVILLE  |  |
| 14. FATHER'S NAME<br>FIRST WILLIAM MIDDLE J. LAST KLUTH, JR.   |              | 15. MOTHER'S MAIDEN NAME<br>FIRST ELLA MIDDLE LOUISE LAST FULLER   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>66-11-579-16-9689  |  | 17. INFORMANT<br>ADDRESS<br>MIRIAM D. KLUTH SAME AS 13 WIFE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>430-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Brain death</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Massive subarachnoid hemorrhage</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>3 days<br>4 days |              |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |              |  |  |   |  |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 Jan 1980</u> , to <u>12 Jan 1980</u> , that (I) (we) last saw the deceased alive on <u>12 Jan 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |              |  |  |   |  |
| 22b. SIGNATURE<br>Eugene P. Libre MD   |              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EUGENE P. LIBRE   |              | 22e. ADDRESS<br>10400 Conn. Ave. MD 20795  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |              | 23b. DATE<br>1/15/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |              | 24. FUNERAL DIRECTOR<br>NAME FRANCIS J. COLLINS ADDRESS<br>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980   |              | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCreedy   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

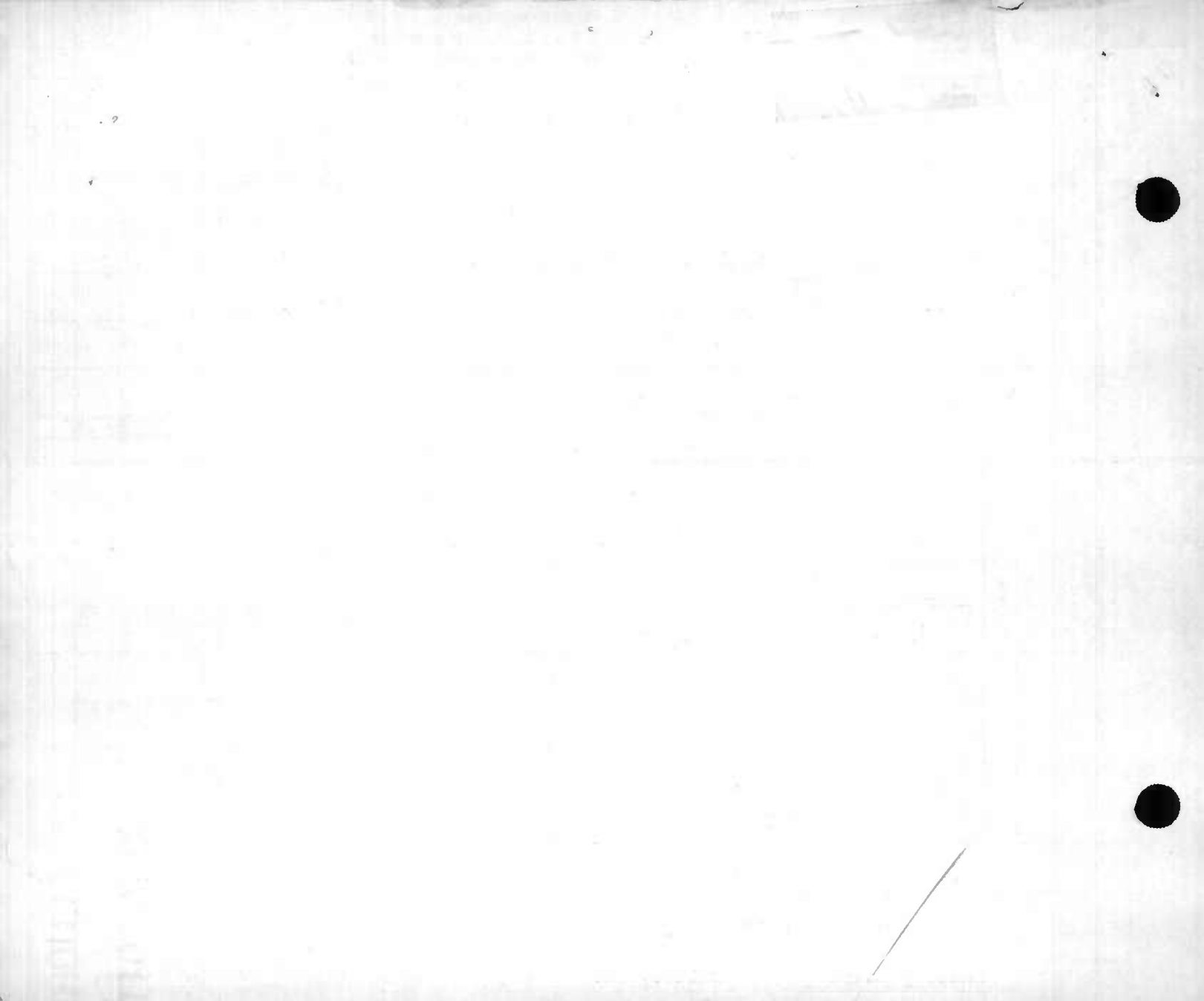


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. 8002064  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Frank Martin Kochanowicz</i>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 20 80</i>                                |  | 2b. HOUR<br><i>12:10 PM</i>  |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 2 19</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hosp.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Mechanic</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Plastic</i>  |  |   |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Mont</i>   |  | 13c. CITY OR TOWN<br><i>Wheaton</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>4407 Randolph Road</i>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WWII</i>  |  | 17. INFORMANT<br>ADDRESS   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIOVASCULAR ARREST</i><br><i>1623</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>metastatic cancer</i><br>(c) <i>Pancreatic tumor</i>                 |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>~ 1 year</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><i>None</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>NA</i>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/29</i> 19 <i>79</i> to <i>1/20</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>1/19</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Bernard Topak MD</i>   |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br><i>1/21/80</i>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BERNARD TOPAK MD</i>  |  |  |  | 22e. ADDRESS<br><i>5454 WILSON AVE. Chevy Chase Md. 20015</i>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>  |  | 23b. DATE<br><i>1/22/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>  |  |  |  | ADDRESS<br><i>Balto., Md.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 28 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>             |  |





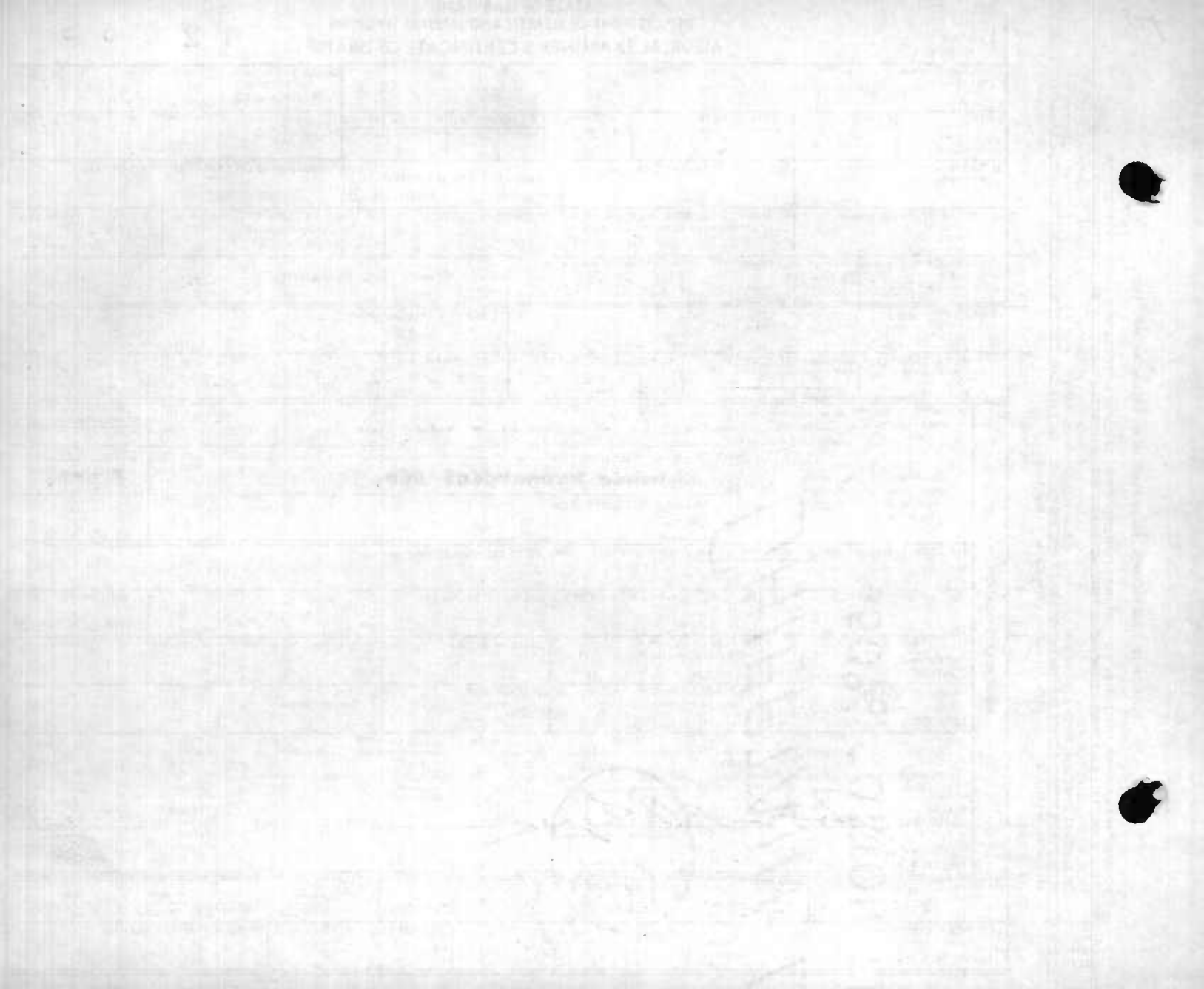
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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3202  
BPDHMH - 17  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |  |                                   |  |                                      |  |                          |  | REG. NO. 02065 |  |             |  |           |  |
|--|---------|--|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|----------------|--|-------------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY            |  | YEAR        |  | HOUR      |  |
| IRVING   |         |  |  |   |  | KOMACK                            |  | Jan 4, 1980                          |  | Jan 4, 1980              |  | Jan 4, 1980    |  | Jan 4, 1980 |  | 6:20 P.M. |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH          |  | DAY         |  | YEAR      |  |
| Male   | White   | Nov 12, 1912   |  | 67 YRS.   |  |                                   |  |                                      |  | Jan 4, 1980              |  | Jan 4, 1980    |  | Jan 4, 1980 |  | 6:20 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |                |  |             |  |           |  |
|  |         | USA  |  | WIDOWED   |  | DIVORCED                          |  | Montgomery                           |  |                          |  |                |  |             |  |           |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                      |  |                          |  |                |  |             |  |           |  |
| Olney  |         | Montgomery General Hospital                              |  | Bookbinder  |  | Graphic Arts                      |  |                                      |  |                          |  |                |  |             |  |           |  |
| 13a. STATE   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Maryland   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 13b. COUNTY  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Montgomery   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 13c. CITY OR TOWN  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Rockville  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 13d. INSIDE CITY LIMITS?   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 13e. STREET ADDRESS  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 14688 Bauer Drive  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 14. FATHER'S NAME  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Louis  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 15. MOTHER'S MAIDEN NAME   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Jennie   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| No   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 16b. SOCIAL SECURITY NO.   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 062-16-5486  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 17. INFORMANT  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Michael Komack, 18208 Mulberry Ct,   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| PART 1 DEATH WAS CAUSED BY:  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Dis.  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 4291   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| (b) Chronic Myocardial Dis.  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| (c)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| None   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 19a. DATE OF OPERATION   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| None   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 20. AUTOPSY?   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21a. EXTERNAL CAUSE WAS  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21b. TIME OF INJURY  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| HOUR A.M. MONTH DAY YEAR   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| P.M. 19  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21d. INJURY OCCURRED   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 21f. LOCATION  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| STREET CITY OR TOWN COUNTY STATE   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| TITLE (SPECIFY)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| M.D.   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| MEDICAL EXAMINER   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| DATE SIGNED Jan 4, 1980  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| ACTUAL SIGNATURE   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| JOHN S. ROGERS, M.D.   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| ADDRESS  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Burial   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 23b. DATE  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 1-7-1980   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Judean Memorial Gardens  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 23d. LOCATION  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| CITY OR TOWN COUNTY STATE  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Olney, Montgomery, Maryland  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 24. FUNERAL DIRECTOR   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| NAME ADDRESS   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 25a. DATE REC'D. BY REGISTRAR  |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| 25b. REGISTRAR'S SIGNATURE   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |
| JAN 8 1980   |         |  |  |   |  |                                   |  |                                      |  |                          |  |                |  |             |  |           |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 0002066            |  |
|--|--|--|--|---|--|--|--|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><u>Joseph A Lambert</u>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>01-10-80</u>   |  | 2b. HOUR<br><u>2:25</u> P M |  |
| 3. SEX<br><u>MALE</u>  |  | 4. RACE<br><u>WHITE</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>04-20-93</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>86</u> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Russia</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD                                 |  |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><u>Wheaton</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Nursing Home</u> |  |   |  | 12a. USUAL OCCUPATION (GIVE LIFE)<br><u>TRANSPORTATION EXECUTIVE</u>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>GIANT FOODS</u>   |  |                             |  |
| 13a. STATE<br><u>MARYLAND</u>  |  | 13b. COUNTY<br><u>MONTGOMERY</u>   |  | 13c. CITY OR TOWN<br><u>SILVER SPRING</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>1111 UNIVERSITY BOULEVARD, WEST</u>   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>ABRAHAM</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>DOBE KAPLAN</u>   |  |   |  |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>057-05-2526A</u>  |  | 17. INFORMANT ADDRESS<br><u>VIVIAN H. LAMBERT, same as #13</u>  |  |  |  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Vascular Disease</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u> |  |  |  |   |  |  |  |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>80</u> , to <u>1-10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1-3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |                             |  |
| 22b. SIGNATURE<br><u>Myron L. Henkin</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><u>1/10/1980</u>  |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Myron L. Henkin</u>  |  | 22e. ADDRESS<br><u>5309 Shorefield Dr Wheaton, Md 20902</u>  |  |   |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>CREMATION</u>  |  | 23b. DATE<br><u>1/12/1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CEDAR HILL CREMATORY</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>WASHINGTON D. C.</u>                           |  |   |  |                             |  |
| 24. FUNERAL DIRECTOR<br><u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u><br><u>232 CARROLL STREET, N.W., WASHINGTON, D. C.</u>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 14 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |                             |  |



MEMORANDUM FOR THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
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BY: [Illegible]  
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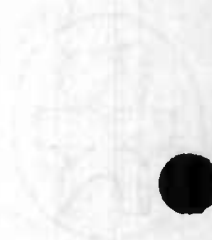
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the appropriate office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8002067   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| I. DECEASED NAME<br>(TYPE OR PRINT)<br>DR. NATHAN T. LANDES  |  |  |  | 7a DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 10, 1980   |  |   |  | 7b HOUR<br>1:00 P.M.   |  |  |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 15, 1905   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD                                |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DOCTOR           |  | 12b KIND OF BUSINESS OR INDUSTRY<br>DENTIST  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN CHEVY CHASE   |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>3301 BROOKLAWN TERRACE  |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL JACOB LANDES   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FRIEDA FEIRSTONE   |  |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>579-22-9226A   |  | 17 INFORMANT ADDRESS<br>SARA LANDES, same as #13   |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1579 CANCER OF THE PANCREAS<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 MO |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) <del>was</del> <sup>did not</sup> attend the deceased from <u>OCT 79</u> to <u>10 JAN 80</u> , that (I) <del>was</del> <sup>did not</sup> lost saw the deceased alive on <u>10 JAN 80</u> , and that in (my) <del>own</del> <sup>best</sup> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <sup>did not</sup> view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b SIGNATURE<br><i>Walter E. Goetz MD</i> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |  |  |   |  | 22c. DATE SIGNED<br>10 JAN 80  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOETZ MD   |  |  |  | 22e ADDRESS<br>2309 SHOREFIELD RD WHEATON MD   |  |   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/11/1980   |  | 23c NAME OF CEMETERY OR CREMATORY<br>KING DAVID MEMORIAL GARDEN FALLS CHURCH VIRGINIA  |  |   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 24 FUNERAL HOME<br>NAME<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N.W., WASHINGTON, D. C.   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  | 25b REGISTRAR'S SIGNATURE<br><i>Robert H. B...</i>                                  |  |  |  |  |  |



DE. PATRICK T. JAMES TO JANUARY 10 1921

PRO-2 JANUARY 10 1921

MEMORANDUM

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

OBJET MAIL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Pauline Laura LANNIER</b>  |  |  |  |   | 2a. DATE OF DEATH<br><b>January 20 1980</b>                     |  |   | 2b. HOUR<br><b>1215p<sub>M</sub></b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>April 25 1927</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maine</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 13a. STATE<br><b>Virginia</b>   |  | 13b. COUNTY<br><b>Prince Wm</b>  |  | 13c. CITY OR TOWN<br><b>Woodbridge</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>13505 Kim Court</b>  |  |
| 14. FATHER'S NAME<br><b>leonard</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Edith</b>                        |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>007-26-7709</b>                  |  | 17. INFORMANT<br><b>Delbert D. Lannier SAA</b>                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) Breast Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>M. J. Duran</i>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>20Jan80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. J. Duran MD</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>National Naval Medical Center</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1-24-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Virginia</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CUNNINGHAM-MOUNTCASTLE</b>   |  |  |  |   |   | ADDRESS<br><b>WOODBRIDGE, VA</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 8 1980</b>   |  |





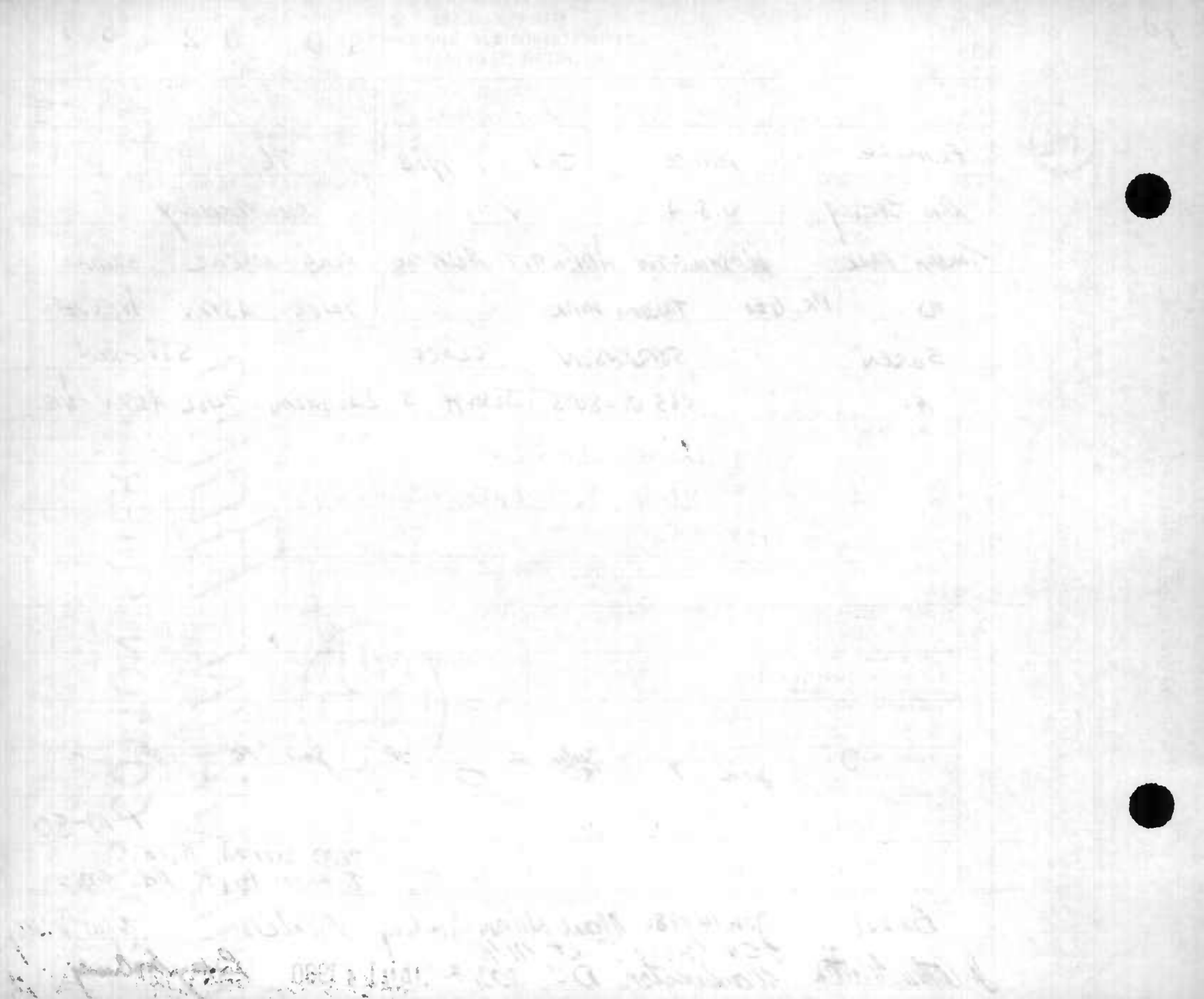
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  |   |  |   |  | 7b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | MONTH DAY YEAR   |  |
| Hannah Clara Laughlin  |  |   |  |   |  |   |  | 1 10 80  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  |
| Female   |  | WHITE   |  | JAN 1 1904  |  | 76 YRS  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| NEW JERSEY   |  | U.S.A.  |  |   |  | MONTGOMERY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |
| TAKOMA PARK  |  | WASHINGTON ADVENTIST HOSPITAL   |  |   |  | FLAG MAKER  |  | SAME   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |
| MD. PR. GEO  |  | TAKOMA PARK   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 7406 ASPEN AVENUE   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| SOREN  |  | SORENSEN  |  | CLARA   |  | ST. GREN  |  | JOSEPH S. LAUGHLIN - 7406 ASPEN AVE                                    |  |
| 18. CAUSE OF DEATH   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?         |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Liver Failure<br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. I certify that (1) (this hospital) attended the deceased from July 2, 19 78, to Jan 10, 19 80, that (2) (we) lost saw the deceased alive on Jan 9, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  | 21h. SIGNATURE<br>John Kijak MD   |  | 21i. DATE SIGNED<br>1-10-80   |  | 21j. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kijak, John                   |  |
| 21k. ADDRESS<br>W A H 7600 Carroll AVE<br>Takoma Park, Md. 20012   |  | 22a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 22b. DATE<br>Jan. 14, 1980  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Mount Hope Cemetery   |  | 22d. LOCATION<br>Montclair New Jersey                                  |  |
| 23. FUNERAL DIRECTOR<br>NAME<br>Arthur Waters  |  | 23a. DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  | 23b. REGISTRAR'S SIGNATURE<br>Lester H. H. H.   |  | 23c. DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  | 23d. REGISTRAR'S SIGNATURE<br>Lester H. H. H.                          |  |



5500

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>James F. Laverty   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 18 1980   |  | 2b. HOUR A<br>2:10 M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 17 <sup>th</sup> 1924  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bethesda Retirement & Nursing Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR LAST 12 MONTHS)<br>Specialists                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5315 Woodlawn Avenue  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Franklin Franklin   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Spurlin  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WWII 463-10-1921  |  | 17. INFORMANT ADDRESS<br>Carolyn W. Laverty, Same as 13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause for item 18a, 18b, and 18c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Epidermoid Pharyngeal Carcinoma</u><br>1490<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/19/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Biopsy louse area  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/2/79</u> 19 <u>79</u> , to <u>1/18</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/19</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>J. Blaine Fitzgerald M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br>1/18/80   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-21-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Maryland                                 |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND   |  |  |  | 25. DATE REC'D BY REGISTRAR<br>JAN 24 1980  |  | 25. REGISTRAR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |  |  |  |

U.S. DEPARTMENT OF COMMERCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth Lawrence</b>  |  |   |  |   |  | 7a. DATE OF DEATH MONTH DAY YEAR<br><b>January 13, 1980</b>                          |  | 7b. HOUR <b>9:36</b> <sup>P</sup> <sub>M</sub>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 18, 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>District of Columbia</b>  |  |   |  |   |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. STREET ADDRESS<br><b>410 M St., SE., Apt. #302</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Adkins</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma U/k</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>None</b>   |  | 17. INFORMANT ADDRESS<br><b>Ms. Marie Singleton, 2338 Pitts Pl, SE Washington, DC 20020</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Colon Carcinoma</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>29</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>1</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from <b>January 10, 1980</b> to <b>January 13, 1980</b> ), that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 13, 1980</b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Aaron Kirkemo MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/14/80</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aaron Kirkemo MD</b>   |  |   |  | 22e. ADDRESS<br><b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan 19, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Mem.Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landover P.G. Maryland</b>          |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 21 1980</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W Rollins Funeral Home, Washington, D.C.</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |  |  |  |  |

BP



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VIRGINIA I. Lawson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>JAN.</b> DAY <b>17</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>9:58 A.M.</b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>2</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma PK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |   |
| 13a. STATE<br><b>MD.</b>   |  |   |   | 13b. COUNTY<br><b>MONT.</b>   |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   | 13e. STREET ADDRESS<br><b>10115 MCKINNEY AVE</b>  |  |   |   |
| 14. FATHER'S NAME<br>FIRST <b>JEFFERSON</b> MIDDLE <b>MURPHY</b> LAST <b>MURPHY</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>TONY</b> MIDDLE <b>ODEN</b> LAST <b>ODEN</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-30-6321</b>  |   | 17. INFORMANT<br><b>SPENCER E. LAWSON, 7443 ANDERSON AVE ROCK.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Superior mesenteric artery rupture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic small &amp; large bowels</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Sepsis</b>  |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>80</b> , to <b>1/17</b> , 19 <b>80</b> , that (I) (we) last<br>saw the deceased alive on <b>1/17</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/17/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Takoma Funeral Home, J. G. White, 251 Carroll Rd, Silver Spring, MD</b>  |  | 22e. ADDRESS  |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 21, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fair Lincoln Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore, P.D. Health</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma Funeral Home, J. G. White, 251 Carroll Rd, Silver Spring, MD</b>   |  | ADDRESS   |   | 25a. DATE REC'D BY REGISTRAR<br><b>1/20/80</b>  |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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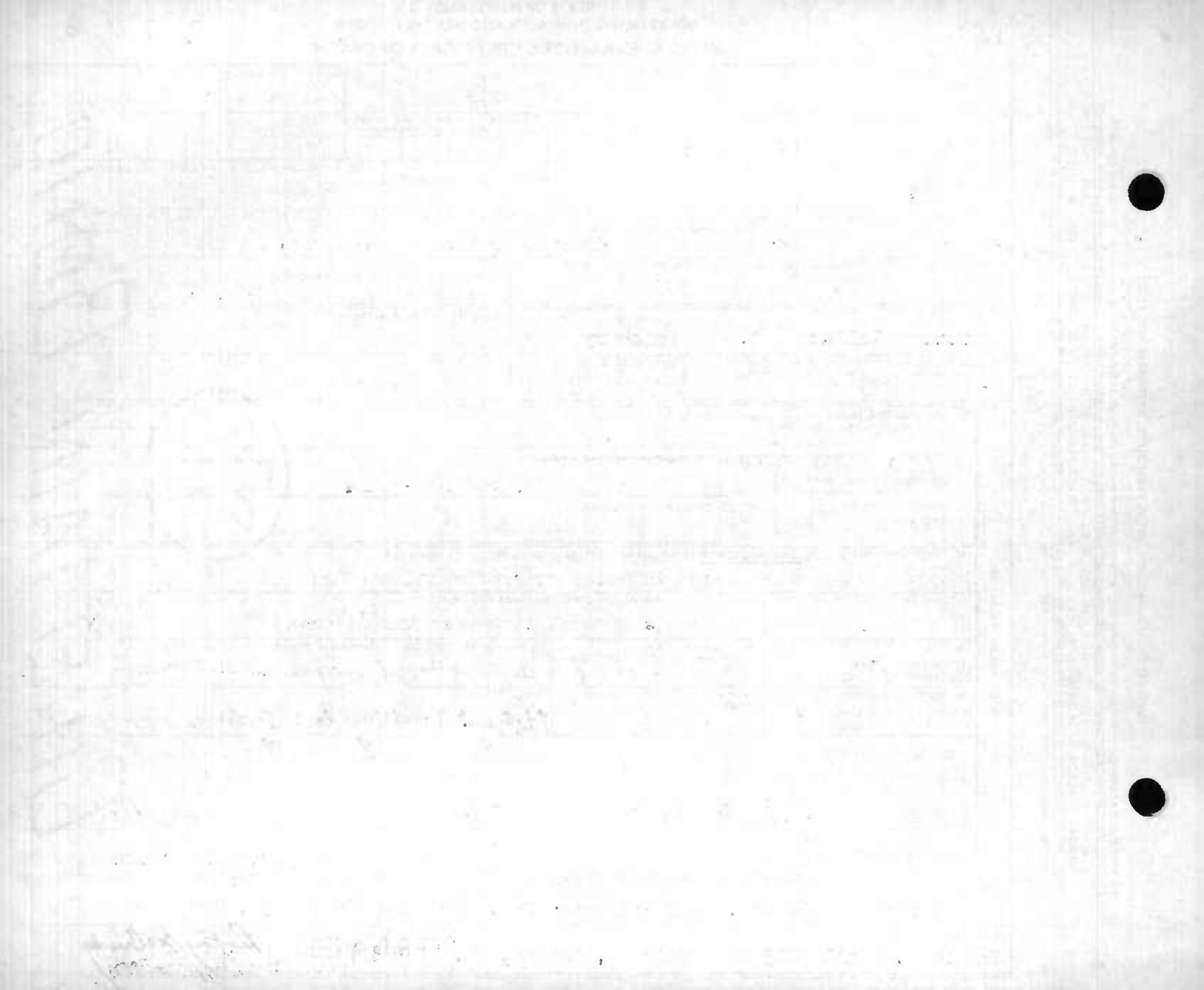
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02073

|  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
|--|--|---|--|--|--|---|--|---|--|---------------------|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR                     |  |  |  |   |  |   |  |                     |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2c. DATE PRONOUNCED DEAD  |  | MONTH DAY YEAR      |  | 2d. HOUR  |  |
| Mary   |  | S   |  | LEEKA  |  |   |  | Jan 25 1980   |  |                     |  | 7:36p   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.    |  | 2c. DATE PRONOUNCED DEAD  |  |
| Female   |  | Cauc  |  | June 28 1914   |  | 65 YRS.   |  | MONTHS DAYS HOURS MIN.  |  | MONTH DAY YEAR      |  | 2d. HOUR  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                     |  |   |  |
| Virginia   |  | USA   |  |  |  | Montgomery County MD.   |  |   |  |                     |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                     |  |   |  |
| Bethesda   |  | National Naval Medical Center   |  | Veterans Admin.  |  |   |  |   |  |                     |  |   |  |
| 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS   |  |   |  |                     |  |   |  |
| Maryland   |  | Ft. Georges   |  | Greenbelt  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 9150 Edmunston Rd   |  |                     |  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |                     |  |   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |  |  |   |  |   |  |                     |  |   |  |
| unknown Wallace t.   |  | Sansbury  |  | Helen  |  | Greer   |  |   |  |                     |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |                     |  |   |  |
| no   |  | 577-12-3195   |  | Brenda E. McHale   |  | See Above   |  |   |  |                     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I DEATH WAS CAUSED BY:  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>   |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| (b) <u>Retroperitoneal Hemorrhage</u>  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| (c) <u>Angiography</u>   |  |   |  |  |  |   |  |   |  |                     |  | 2½ hours  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| Severe coronary and systemic atherosclerosis and cardiomegaly  |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                     |  | 20. AUTOPSY?  |  |
| 25 Jan 1980  |  |   |  | diagnosis of occlusive vascular disease  |  |   |  |   |  |                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                     |  |   |  |
|  |  |   |  | 5:00 P.M. 1-25 1980  |  |   |  | Arterial catheterization caused laceration of artery Hemorrhage               |  |                     |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |                     |  |   |  |
|  |  |   |  | Hospital   |  |   |  | National Naval Med. Center Bethesda Montgomery Md.                            |  |                     |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |   |  |  |  |   |  |   |  |                     |  |   |  |
| ACTUAL SIGNATURE   |  |   |  | TITLE (SPECIFY)  |  |   |  | MEDICAL EXAMINER  |  |                     |  | DATE SIGNED   |  |
| John G. Ball   |  |   |  | M.D. Deputy  |  |   |  |   |  |                     |  | Jan. 26, 1980   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |   |  | ADDRESS  |  |   |  |   |  |                     |  |   |  |
| John G. Ball   |  |   |  | 7936 Old Georgetown Rd., Bethesda, Md  |  |   |  |   |  |                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |   |  | 23d. LOCATION       |  |   |  |
| Burial   |  |   |  | 30 Jan. 1980   |  | Arlington Nat. Cemetery   |  |   |  | Arlington, Virginia |  |   |  |
| 24. FUNERAL DIRECTOR   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                     |  |   |  |
| NAME Robert G. Beall   |  |   |  | ADDRESS 9013 Annapolis Rd. Lanham, Md.   |  |   |  | FEB 04 1980   |  |                     |  | Anthony McCreedy  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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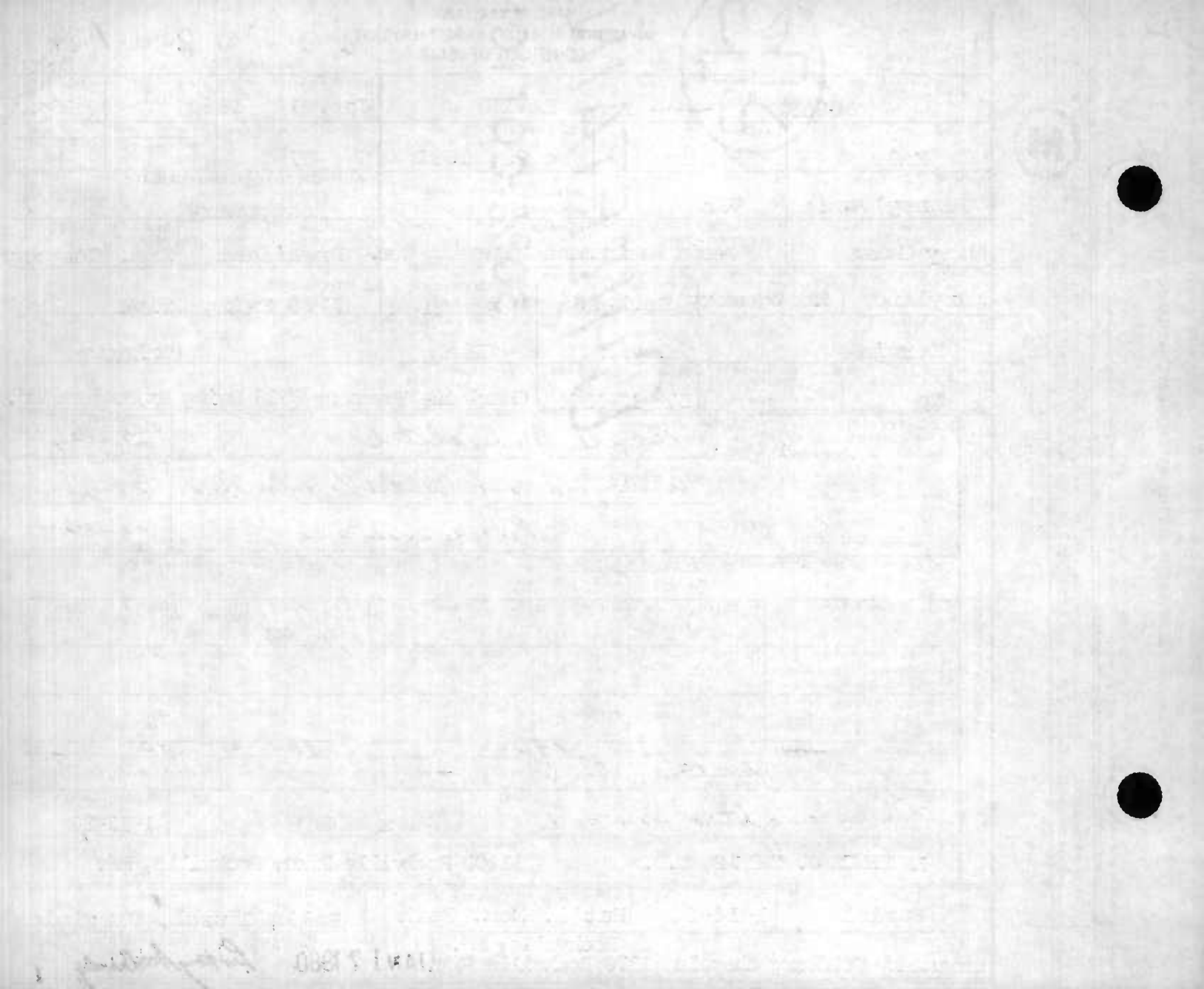
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 30 02074  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH ----- LEVIN</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 12, 1980</b>  |  | 2b. HOUR<br><b>4:25p.m.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 25, 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Retirement &amp; Nursing Ctr.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>President</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ins. Company</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>8728 Ewing Drive</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Morris ----- Levin</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leah (unknown)</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-12-1364</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Charlotte Yavener; 8728 Ewing Dr, Bethesda Md.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Acute Bronchitis</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b): <b>Arteriosclerotic Cardiovascular Dis</b><br>(c): <b>Pneumonia</b> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>25 years</b><br><b>10 years</b>                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1960</b> 19 to <b>JAN 12</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Jan 12</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Thomas M.D.</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-12-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE J. THOMAS, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>11801 Rockville Pike, Rockville, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-14-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l. Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry A. Brady</b>  |  |  |  |

MEDICAL CERTIFICATION

29

1

4600  
BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                               | 8 0 0 2 0 7 5<br>REG. NO.   |  |
|--|---|--|-------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth S. Lewis  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 18 80   |                               | 2b. HOUR<br>10 <sup>45</sup> P. M.  |  |
| 3 SEX<br>Female  | 4 RACE<br>Caucasian   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 11, 1895   |                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Bethesda | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sylvane Sharp   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Eccles  |                               | 13e. STREET ADDRESS<br>10670 Weymouth Ave., Apt. 103  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Unknown   |                               | 17 INFORMANT (Son)<br>Stephen S. Lewis<br>ADDRESS 6012 Poindexter Ln.<br>Rockville, Md.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Gram negative Sepsis</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Bowel perforation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of Stomach - metastatic</u> |   |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 hrs<br>16 hrs<br>years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |  |                               |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-14-80, 19, to 1-18-80, 19, that (I) (we) last saw the deceased alive on 1-18-80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |                               |   |  |
| 27b. SIGNATURE<br>Jeremy V. Cooke  |   | DEGREE<br>MD   |                               | 27c. DATE SIGNED<br>1/19/80   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeremy V. Cooke   |   | 27e. ADDRESS<br>10400 Conn Ave. Kensington   |                               | 27f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>Jan. 22, 1980   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Park Cemetery   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Capitol Funeral Service   |   | ADDRESS<br>Fairfax, Va.  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>New Castle, Penna.  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>P. McCready  |                               |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 7a, 7b g540 2/14/80 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARVEY</b>   |  |  | FIRST<br><b>LEWIS, JR.</b>  |  |  | LAST   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 09 80</b>   |  |  | 2b. HOUR<br><b>0953 AM</b>                               |  |  |
| 3. SEX<br><b>male</b>  |  |  | 4. RACE<br><b>Black</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 23 50</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>29</b> YRS.  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>7</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY GROVE ADVENTIST HOSP.</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DEPT. OF ECOLOGY</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>MONT.</b>   |  |  | 13c. CITY OR TOWN<br><b>GAITHERSBURG</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  | 13e. STREET ADDRESS<br><b>19944 SPARKHILL DRIVE</b>      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARVEY L. LEWIS, SR.</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GLORIA GAYLOR</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>5770688-0839</b>   |  |  | 17. INFORMANT<br><b>Gwendolyn Lewis-Wife Same as 12a</b>   |  |  | ADDRESS  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest - asystolic</b><br><b>1990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myeloph + Diffuse Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph A. Fortuna, MD.</b>  |  |  |   |  |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |  |  | 22c. DATE SIGNED<br><b>1/9/80</b>                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH A. FORTUNA</b>  |  |  |   |  |  | 12a. ADDRESS<br><b>SHADY GROVE ADVENT. HOSPITAL</b>  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/12/80</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landover, Md.</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MORROW &amp; WOODFORD</b>   |  |  |   |  |  | ADDRESS<br><b>1622 11th. St. Wash., D. C.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John R. Brady</b>       |  |  |

727-18-0830 (John Lewis - 112)

40. K. H. S.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 1 YEAR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

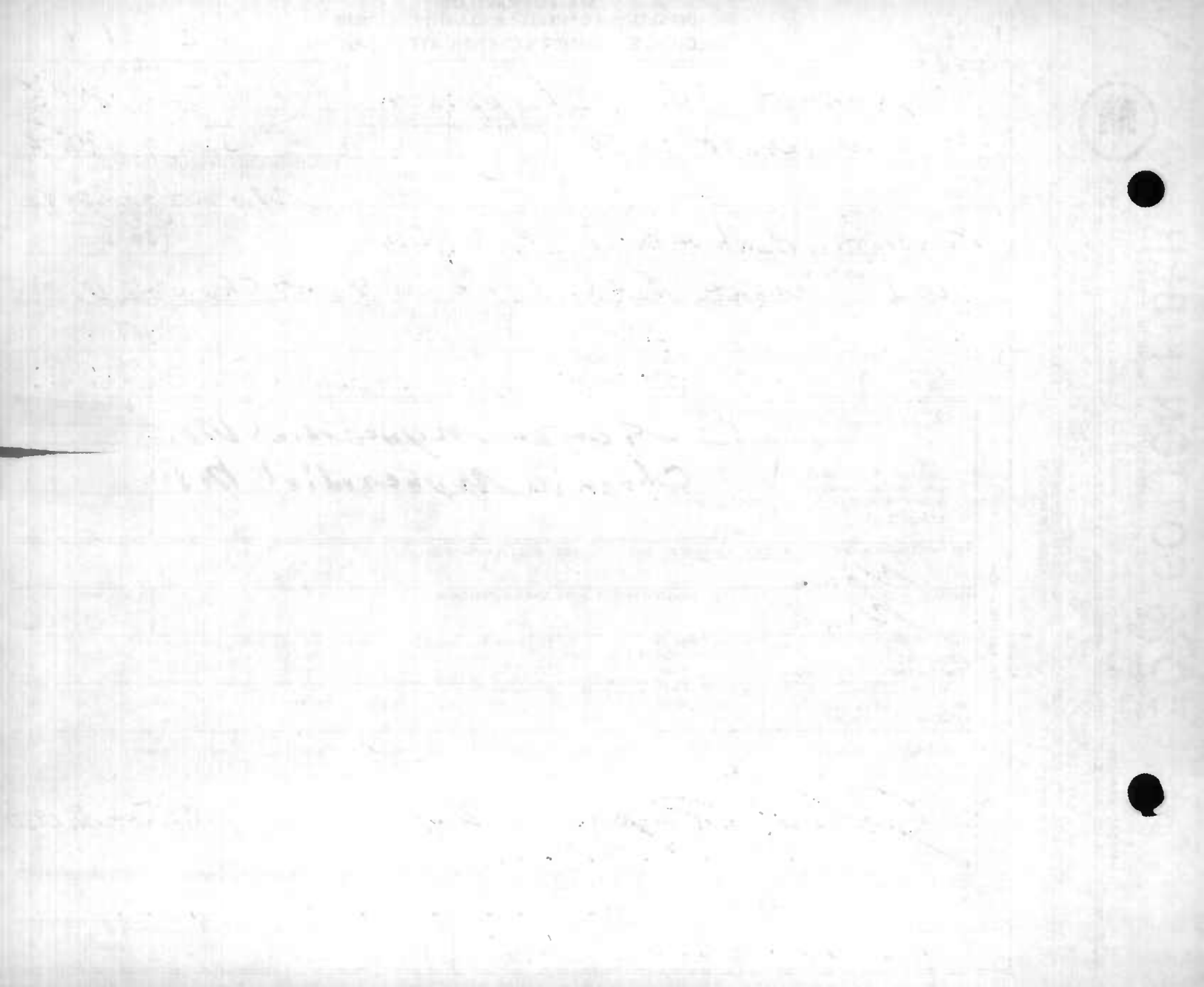
BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02077

|  |  |                                     |  |  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
|--|--|-------------------------------------|--|--|--|--------------|--|---|--|---|--|---|--|---|--|--|--|-------------------|--|-------------------|--|--|--|
| FOR<br>1- STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>Robert  |  | MIDDLE<br>S. |  | LAST<br>Lippman   |  | 2a. DATE KNOWN OF DEATH                       |  | MONTH<br>Jan  |  | DAY<br>9                                |  | YEAR<br>1980                           |  | 2b. HOUR<br>11:30 |  |                   |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W                        |  | 5. DATE OF BIRTH<br>MONTH<br>Dec   |  | DAY<br>20    |  | YEAR<br>1959  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>20 |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.       |  | 2c. DATE PRONOUNCED DEAD<br>Jan 9 1980 |  | 2d. HOUR<br>11:30 |  |                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |  |  |  |                   |  |                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Kensington Park & Bethesda Park   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kensington Park & Bethesda Park |  |              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Jeweler  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Jewelry  |  |   |  |  |  |                   |  |                   |  |  |  |
| 13a. STATE<br>MD   |  |                                     |  | 13b. COUNTY<br>Montgomery  |  |              |  | 13c. CITY OR TOWN<br>Bethesda   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9209 Chanute Dr. |  |  |  |                   |  |                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Simon  |  |                                     |  | MIDDLE<br>Lippman  |  |              |  | LAST<br>Lippman   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Sadie  |  |   |  | MIDDLE<br>Baylinson                    |  |                   |  | LAST<br>Baylinson |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |  |                                     |  | 16b. SOCIAL SECURITY NO.<br>Korean   |  |              |  | 158-09-3422   |  |   |  | 17. INFORMANT<br>Lois M. Lippman; 9209 Chanute Dr.  |  |   |  | ADDRESS<br>Bethesda, Md.               |  |                   |  |                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Chronic Myocardial Dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |                                     |  |  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>None</u>   |  |                                     |  |  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                     |  |  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                     |  |  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| ACTUAL SIGNATURE<br><u>John S. Rogers</u>  |  |                                     |  | TITLE (SPECIFY)<br>M.D. <u>Dep.</u>  |  |              |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>Jan. 9, 1980   |  |   |  |  |  |                   |  |                   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>JOHN S. ROGERS, M.D.  |  |                                     |  | ADDRESS  |  |              |  |   |  |   |  |   |  |   |  |  |  |                   |  |                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                                     |  | 23b. DATE<br>1-11-80   |  |              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wash. Heb. Cong. Cem.   |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>Washington, D.C.   |  |   |  |  |  |                   |  |                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels;  |  |                                     |  | ADDRESS<br>Rockville, Md.  |  |              |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCready</u>  |  |   |  |  |  |                   |  |                   |  |  |  |



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, this certificate should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                   |  | 8 0 0 2 0 7 8<br>REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| KURT M. LOEWY   |  | Jan. 20, 1980  |  | 6:45 p.m.  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| Male  |  | White  |  | Dec. 17, 1903  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  |
| Germany   |  | USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Silver Spring   |  | University Nursing Home  |  | Accountant   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. STREET ADDRESS  |  |
| Maryland  |  | Montgomery   |  | 1131 University Blvd.W.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| Max Loewy   |  | Rose Bayreuther  |  | No   |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Prostatic Carcinoma</u> |  |
| 353-22-9528   |  | Marvin R. Loewy, 6 Dairyfield Ct., Rockville   |  | 185- DUE TO, OR AS A CONSEQUENCE OF  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
| 1971  |  | Carcinoma - Prostate   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>11/11/79</u> to <u>1/20/80</u> , that (1) <u>was</u> lost above, (1) <u>was not</u> view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |
|   |  | Earle B. Thompson M.D.   |  | 1/21/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |
| Earle B. Thompson, M.D.   |  | 6111 Executive Blvd., Rockville, Maryland  |  | Burial   |  |
| 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| 1-24-1980   |  | Jewish Waldheim Cemetery   |  | Forest Park, Illinois  |  |
| 24. FUNERAL DIRECTOR  |  | 25. DATE REC'D BY REGISTRAR  |  | 26. REGISTRAR'S SIGNATURE  |  |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike   |  | JAN 25 1980  |  | [Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002079

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |   |   |   |
|--|--|---|--|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie L. Luckett</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-23-80</b>                      |  |  | 2b. HOUR<br><b>9:45</b> AM  |   |   |   |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 16 1893</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>86</b>     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co. MD.</b>   |   |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda, Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Payroll Supv.</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Tel Co.</b> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Darnestown</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Butler Dickenson</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Annie Carneal</b> |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>577-01-1667</b>   |  |   | 17 INFORMANT<br><b>James E. Luckett Darnestown, Md.</b>                    |  |  | 17 ADDRESS<br><b>15605 Jones Lane 20760</b>   |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory failure &amp; cardiac arrest</b><br><b>5750</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiac arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiac arrest.</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/20/80 - 3 days</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Perforating acute cholecystitis and gas gangrene. Atrial fibrillation &amp; Cardiac failure</b>   |  |   |  |  |  |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>1/13/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Perforating Acalchopayshite abdominal abscess</b>                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13/80</b> , 19____, to <b>1/23/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/23/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |   |   |   |
| 22b. SIGNATURE<br><b>S.B. Goswami MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c. DATE SIGNED<br><b>1/24/80</b>                            |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S.B. GOSWAMI</b>   |  |   |  | 22e. ADDRESS<br><b>5401 Graystone St. Chch. Md. 20015</b>  |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 28, 80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>   |   |   |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hines/Rinaldi Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry K. [Signature]</b>   |   |   |   |
| 26. ADDRESS<br><b>11800 New Hampshire Ave. Silver Spring, Md.</b>  |  |   |  |  |  |   |   |   |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Donald</b>   |  | FIRST <b>DONALD</b>   |  | MIDDLE <b>G.</b>  |  | LAST <b>MacIVER</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>25</b> YEAR <b>80</b>   |  | 2b. HOUR<br><b>7:50 PM</b>                            |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>Mar.</b> DAY <b>16</b> YEAR <b>1904</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CANADA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel &amp; Restaurant</b>   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>ontgomery</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>8500 New Hampshire Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Neil</b> MIDDLE <b></b> LAST <b>MacIver</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Bella</b> LAST <b>Matheson</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO<br><b>1922-1926</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret F MacIver, Wife. Same as item 13.</b>        |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiac insufficiency</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>COPD, pulm emboli, abdomen surgical procedure, alcohol</b>   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b></b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br>P.M. <b></b>                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |  |  |  |  |  |   |  |
| 22a. I certify that (if in this hospital) attended the deceased from <b>early december 1979</b> to <b>1/23/80</b> 19 <b></b> , that (I) (we) lost<br>saw the deceased alive on <b>1/24/80</b> 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (if we) (did) (did not) see the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Elmer R. Gowstein</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/27/80</b>                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELMER R. GOWSTEIN</b>   |  |   |  | 22e. ADDRESS<br><b>9410 OLD GEORGETOWN BETH. MD</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial/Removal</b>   |  | 23b. DATE<br><b>1/29/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Queens Lawn Cemetery</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Grimbsy</b> COUNTY <b>CANADA</b> STATE <b></b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons Inc</b> ADDRESS<br><b>5130 Wisc Ave. N.W.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Peter A. B...</b>                                   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |   |   |   |   |  |  |   |  |
|--|--|--|--|--|---|---|---|---|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>DOROTHY</b>   |  |  | First <b>M.</b>  |  | Middle <b>MADERT</b>                                    |   | Last  |   | 2a. DATE OF DEATH<br><b>1</b> Month <b>31</b> Day <b>80</b> Year                                    |  | 2b. HOUR<br><b>8:33 AM</b>   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |   | 5. DATE OF BIRTH<br><b>OCT 25, 1905</b>   |   |   | 6. AGE (In years last birthday)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address)<br><b>CARRIAGE HILL NURSING HOME</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>DEPT OF AGRICULTURE</b>                                       |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>PRINCE GEO.</b>  |  |   | 13c. CITY OR TOWN<br><b>HYATTSVILLE</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |  | 13e. STREET AND NUMBER<br><b>2002 BEECHWOOD ROAD</b>  |  |
| 14. FATHER'S NAME<br><b>GEORGE</b>   |  |  | First  |  | Middle  |   | Last  |   | 15. MOTHER'S MAIDEN NAME<br><b>RUBY L. CHILDS</b>   |  |  | First Middle Last                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>  |  |  | (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-42-2875</b>  |   |   | 17. INFORMANT<br><b>EXECUTOR MARY J. EASTHAM</b><br><b>2412 FORDHAM PLACE HYATTSVILLE, MARYLAND</b> |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopul. arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Metastatic CA of uterus - Brain</b><br>(b) <b>uterine CA.</b><br>(c) <b>1 yr</b> |  |  |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>month</b> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>   |  |  |  |  |   |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-9</b> , 19 <b>80</b> , to <b>1-31</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1-30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |   |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>John Ford M.D.</b>  |  |  |  |  |   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/31/80</b>                           |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN L FORD</b>   |  |  |  |  |   |   |   | 22e. ADDRESS<br><b>344 University Blvd W Silver Spring Md</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>2/4/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b> |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>SUITLAND PRI GEO MD.</b>  |   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b>  |  |  |  |  |   |   |   | ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 1 1980</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b> |  |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
|---|--|--|-------------------|--|--|--|--|--|-----------------------------------|--|----------|--|
| REG. NO. 8002082  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR                    |  | 2b. HOUR |  |
| Moomi (NMN)   |  |  | Magruder          |  |  | 1  |  |  | 12                                |  | 80       |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |                                   | 7. IF UNDER 24 HRS   |          |  |
| FEMALE  |  | CAUCASIAN  |                   | JAN. 31 1895   |  | 84   |  | MONTHS DAYS  |                                   | HOURS MIN  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |  |          |  |
| MARYLAND  |  | U.S.A.   |                   |  |  | MONTGOMERY   |  |  |                                   |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |
| ROCKVILLE   |  | ROCKVILLE NURSING HOME   |                   |  |  | RETIRED SALES  |  |  | SALES                             |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| 13a. STATE  |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |                                   |  |          |  |
| MARYLAND  |  | MONTGOMERY   |                   | ROCKVILLE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 236 FALLS RD.  |                                   |  |          |  |
| 14. FATHER'S NAME   |  |  |                   | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |                                   |  |          |  |
| FIRST MIDDLE LAST AMOS W. MAGRUDER  |  |  |                   | FIRST MIDDLE LAST MOLLIE WILSON  |  |  |  |  |                                   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |                   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |                                   |  |          |  |
| NO  |  |  |                   | 217-01-9723A   |  | VIOLET MAGRUDER (SAME AS 13e)  |  |  |                                   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u>  |  |  |                   |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> |          |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>disorder</u>  |  |  |                   |  |  |  |  |  |                                   | 10 years   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pyelonephritis</u>  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |          |  |
| None  |  |  |                   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |                                   |  |          |  |
| <input type="checkbox"/>  |  | HOUR A.M. MONTH DAY YEAR P.M. <u>none</u> 19   |                   |  |  |  |  |  |                                   |  |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY   |                                   | STATE  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |                   | STREET   |  |  |  |  |                                   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> 19 <u>80</u> , to <u>Jan 12</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Jan 8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| 22b. SIGNATURE  |  |  |                   |  |  | DEGREE   |  | 22c. DATE SIGNED   |                                   |  |          |  |
| <u>Stephen C. Cromwell, MD</u>  |  |  |                   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 1-12-80  |                                   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |                   |  |  | 22e. ADDRESS   |  |  |                                   |  |          |  |
| Stephen C. Cromwell, M.D.   |  |  |                   |  |  | 615 W. Montgomery, Rockville, Md   |  |  |                                   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |                                   |  |          |  |
| BURIAL  |  | 1-15-80  |                   | MT. ZION CEMETERY  |  | CITY OR TOWN COUNTY STATE BETHESDA MONTG. MD.  |  |  |                                   |  |          |  |
| 24. FUNERAL DIRECTOR  |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| NAME ADDRESS ROCKVILLE MD. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |  |                   |  |  |  |  |  |                                   |  |          |  |
| ROBERT A. PUMPHREY FUNERAL HOMES P/A JAN 22 1980 <u>Robert A. Pumphrey</u>  |  |  |                   |  |  |  |  |  |                                   |  |          |  |

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REMARKS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8002033  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST RUTH  |  | MIDDLE BEAVERS  |  | LAST MAGRUDER   |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 20 80  |  |
| 3. SEX Female  |  | 4. RACE CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 17 93   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 87  |  | 2b. HOUR 415 P M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL E.C.F. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife           |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN WASHINGTON  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 4429 BRANDYWINE St. N.W.  |  |
| 14. FATHER'S NAME FIRST John MIDDLE m LAST BEAVERS   |  | 15. MOTHER'S MAIDEN NAME FIRST Hattie MIDDLE may LAST BRUCE   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO. 579-60-9927   |  | 17. INFORMANT ADDRESS Rd., McLean, Virginia Mrs Thornton M. Jordon, Dtr. 8360 Greensboro                                    |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.  |  |
| 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart failure  |  |   |  |   |  |   |  | 24 hrs.   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease   |  |   |  |   |  |   |  | years.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Organic brain syndrome   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from Jan 20 19 79, to Jan 20 19 80, that (a) (we) lost saw the deceased alive on Dec 13 19 79, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE James Coleman   |  | DEGREE  |  | 22c. DATE SIGNED 1/20/80  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R COLEMAN  |  | 22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING, Md 20910   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 1/23/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.                       |  |   |  |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR JAN 24 1980   |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |   |  |

THE UNIVERSITY OF CHICAGO  
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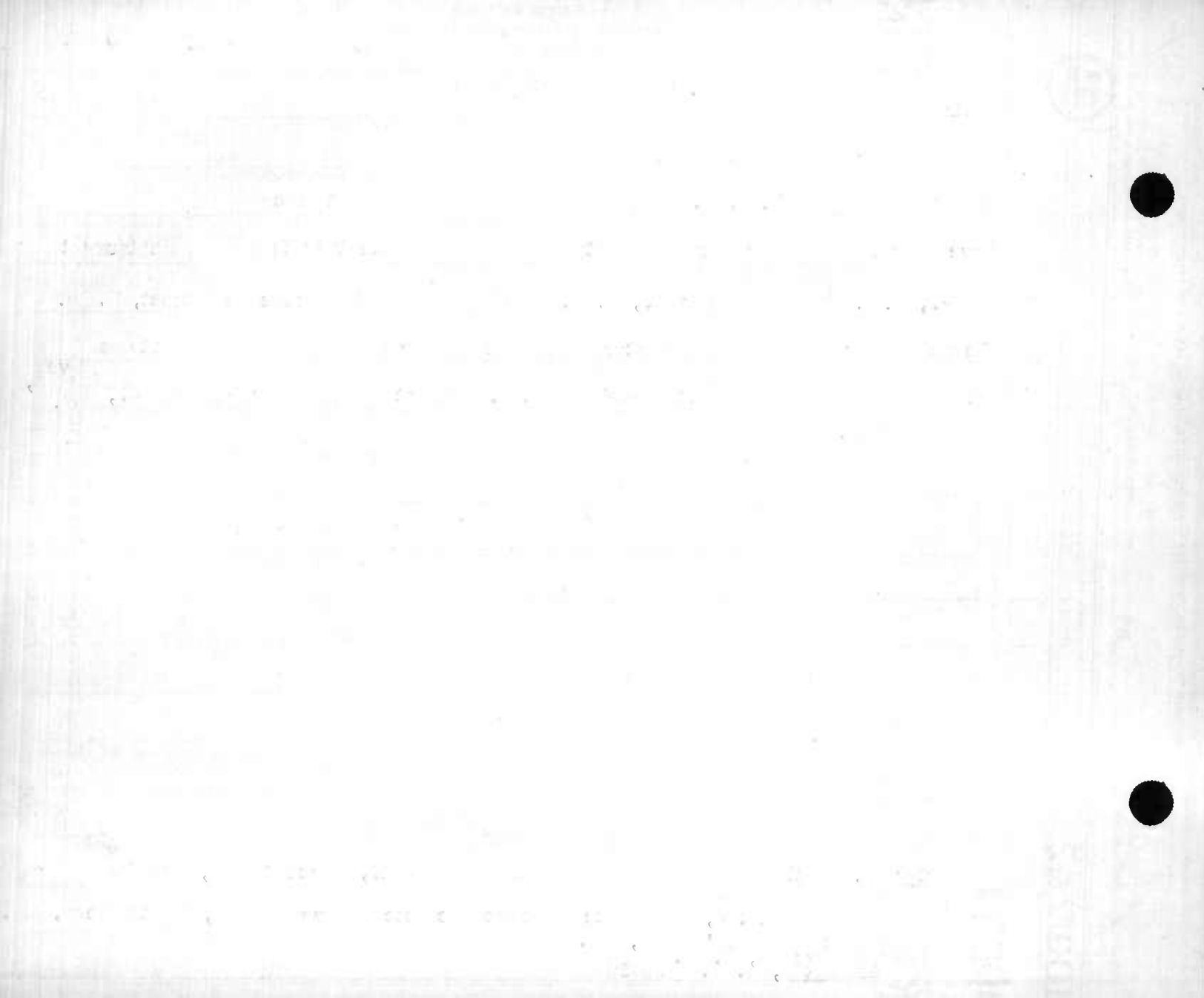
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8002084             |  |
|---|--|---|--|---|--|--|--|---|--|------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>IOANNIS G. MANOLATOS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>01 31 80</b>   |  | 2b. HOUR <b>8:55P M</b>   |  |                              |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Romania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurateur</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>   |  |                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Wash., D. C.</b> 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN <b>Wash., D. C.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3413 Fessenden Street, N. W.</b>   |  |                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Gerasimos Manolatos</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Spyridoula Portulos</b>   |  |  |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>577-09-1403 A</b>   |  | 17. INFORMANT ADDRESS <b>C. J. Manolatos 1502 Timberline Rd., Silver Spring, Md.</b>         |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sandwich eaten while per</b><br><b>1889</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>concomitant with</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>concomitant with</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 weeks</b><br><b>9 years</b> |  |   |  |   |  |  |  |   |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1977</b> to <b>1980</b> , that (I) (we) lost saw the deceased alive on <b>1/25</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |                              |  |
| 22b. SIGNATURE <b>Arthur J. Wilets</b>  |  |   |  | DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  |  |  | 22c. DATE SIGNED <b>2/2/80</b>  |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur J. Wilets</b>   |  |   |  | 22e. ADDRESS <b>1111 Spring St., Silver Spring, Maryland</b>  |  |  |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Feb. 4, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Montgomery, Md.</b>                |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N. W. Washington, D. C. 20016</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>   |  |                              |  |

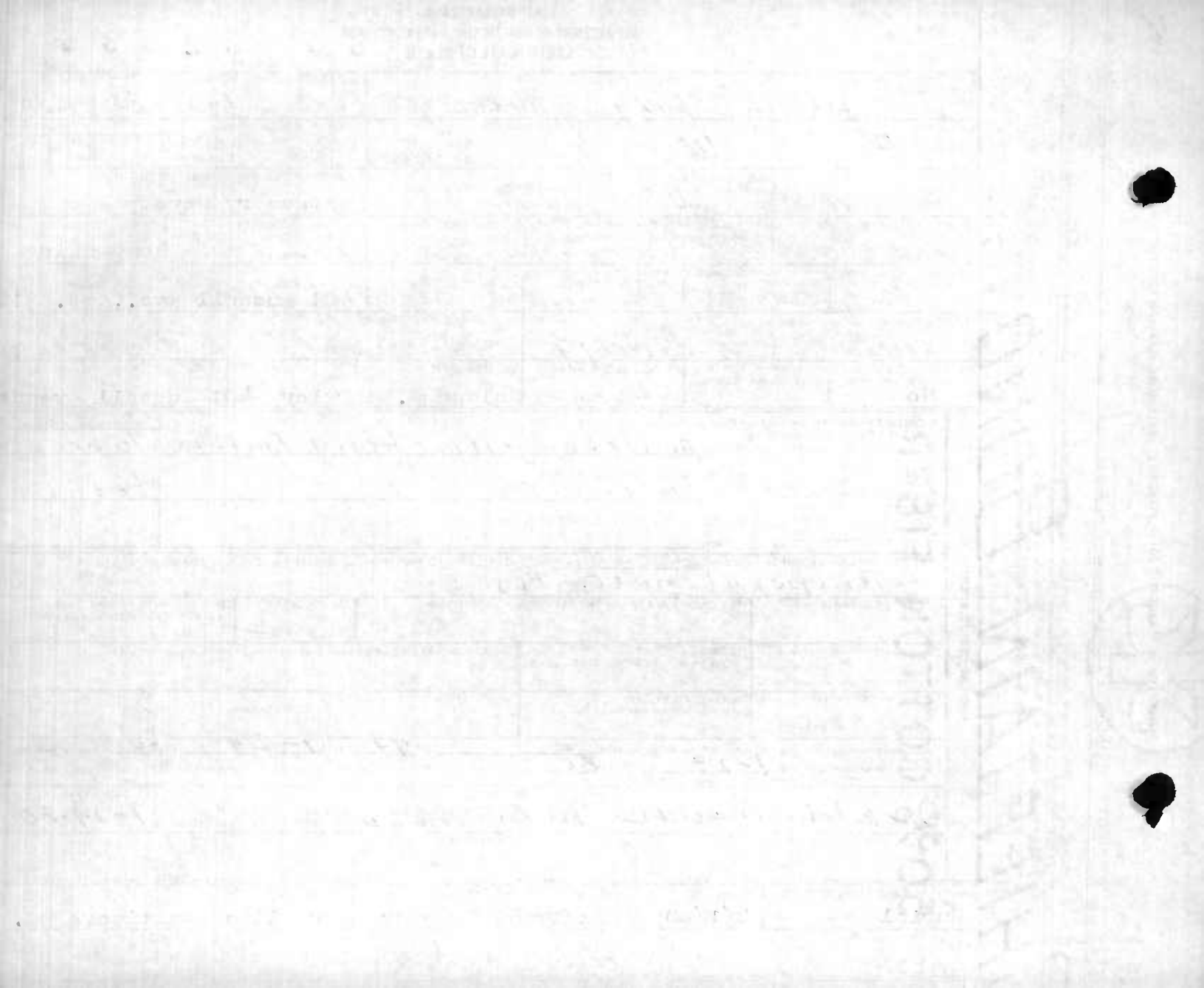


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LORETTA M MARKLEY</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-29-80</b>   |  | 2b. HOUR<br><b>11:30<sup>AM</sup></b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-25-1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>GAITH. MD.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WILSON HEALTH CARE CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                               |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>MONTE</b> 13c. CITY OR TOWN <b>GAITHERS.</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>401 Russell Ave., Apt. 312</b>                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARTIN NEUBERGER</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE WIRTZBERGER</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-09-634-B</b>  | 17. INFORMANT<br>ADDRESS<br><b>Roland E. Markley 401 Russell Avenue</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>H-C. V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Temporal arteritis</b>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>15 hours</b><br><b>Years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Temporal arteritis</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1974</b> to <b>1-29</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-28</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Jack Schumacher M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1-29-80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>2/1/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LASSAHN F.X.</b>   |   | ADDRESS<br><b>7401 BELAIR RD 21266</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1980</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002086  
REG. NO.

|  |                             |   |  |   |  |
|--|-----------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Marshall</b>  |                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 23 80</b>   |  | 2b. HOUR<br><b>2:00 AM</b>  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>CAUCASIAN</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR 26 85</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont Co</b>   |                             | MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville, Md.</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                             |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>  |                             | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Marshall</b>   |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret McKinlly Marshall</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                             | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>John Marshall, Bethesda, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                             |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Gastrointestinal bleeding</b>  |                             |   |  |   |  |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br><b>we</b>   |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (a) (this hospital) attended the deceased from <b>June 1978</b> , to <b>Jan 23</b> , 19 <b>80</b> , that (we) lost saw the deceased alive on <b>1-17</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.                                    |                             |   |  |   |  |
| 22b. SIGNATURE<br><b>James W. Egan M.D.</b>  |                             | DEGREE  |  | 22c. DATE SIGNED<br><b>1/23/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. EGAN</b>  |                             | 22e. ADDRESS<br><b>5413 Cedarkn - Bethesda, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                             | 23b. DATE<br><b>1/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lonaconing A. Md</b>  |                             |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eichhorn Funeral Home</b>   |                             | ADDRESS<br><b>Lonaconing, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McCreedy</b>  |                             |   |  |   |  |

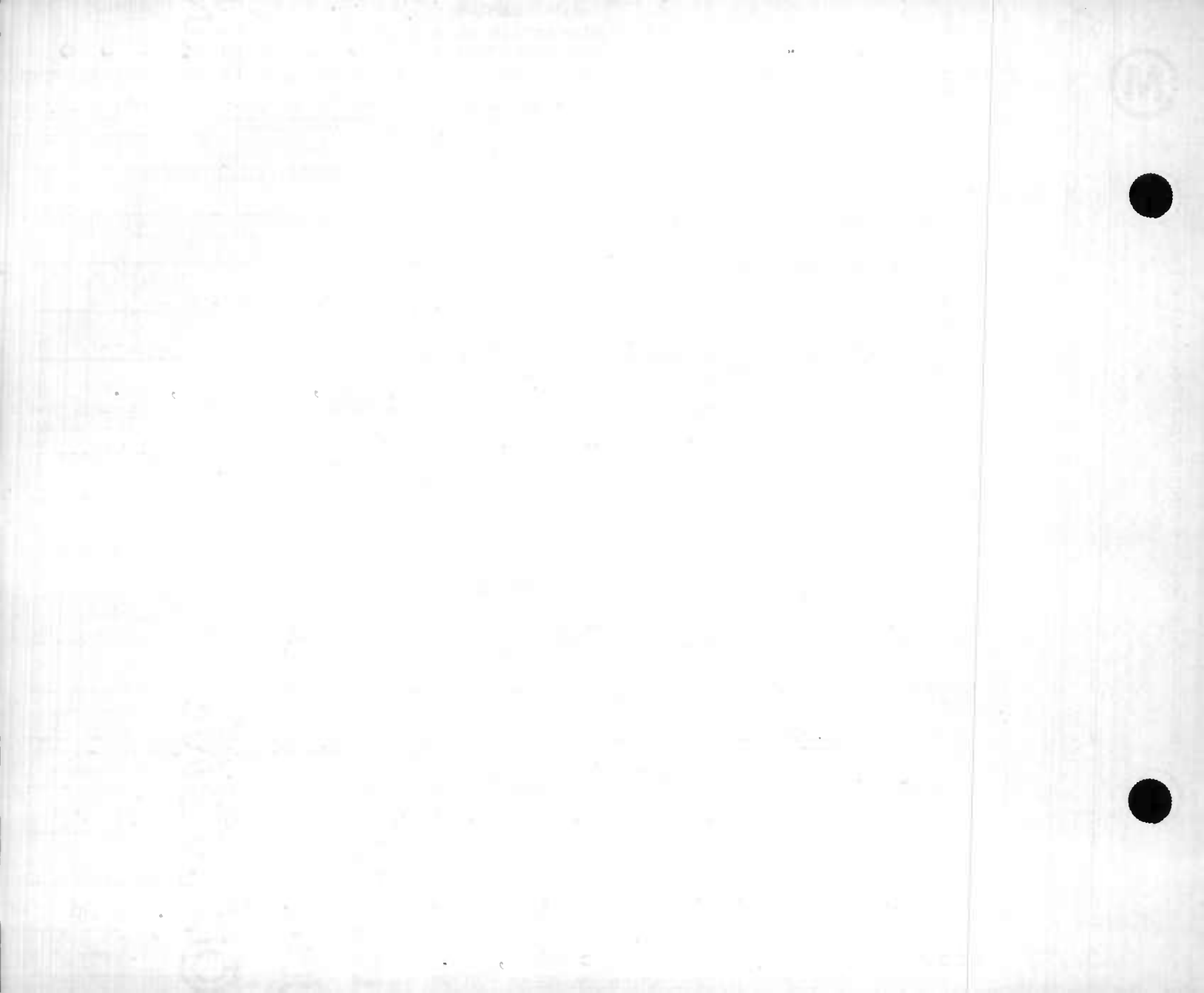
35  
70  
35  
50  
1  
2  
9  
1  
4503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Checked by Dr. Ball

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

checked by Dr. Ball - not a nurse

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  | 8002087 |  |
|--|--|--|--|---|---|--|--|--|--|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |   |  |  |  |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Roy Edward Marth   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01-04-80   |  |  | 2b. HOUR<br>0949 AM  |  |         |  |
| 3. SEX<br>M  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09-4-14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>WELDER                    |  |         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>903 GILBERT RD.   |  |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM GEORGE MARTH   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADA CARTER                                     |  |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>213-01-8737  |  | 17. INFORMANT ADDRESS<br>ANITA L. MARTH (SAME AS 13e)   |   |  |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br><u>and congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Cirrhosis of liver, chronic obstructive pulmonary disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Cirrhosis of liver, chronic obstructive pulmonary disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>2 years |  |  |  |   |   |  |  |  |  |         |  |
| 19a. DATE OF OPERATION<br>none   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>none   |   |  |  |  |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26 1954</u> to <u>Jan 4 1980</u> , that (I) (we) last saw the deceased alive on <u>Nov 8 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |         |  |
| 22b. SIGNATURE<br>Stephen C. Cromwell MD   |  |  |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-4-80                                     |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen C. Cromwell, M.D.   |  |  |  | 22e. ADDRESS<br>615 W. Montgomery Ave<br>Rockville, Md 20850  |   |  |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-7-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FOREST OAK CEMETERY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GAITHERSBURG MONTG. MARYLAND   |  |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A ROCKVILLE MD.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |         |  |



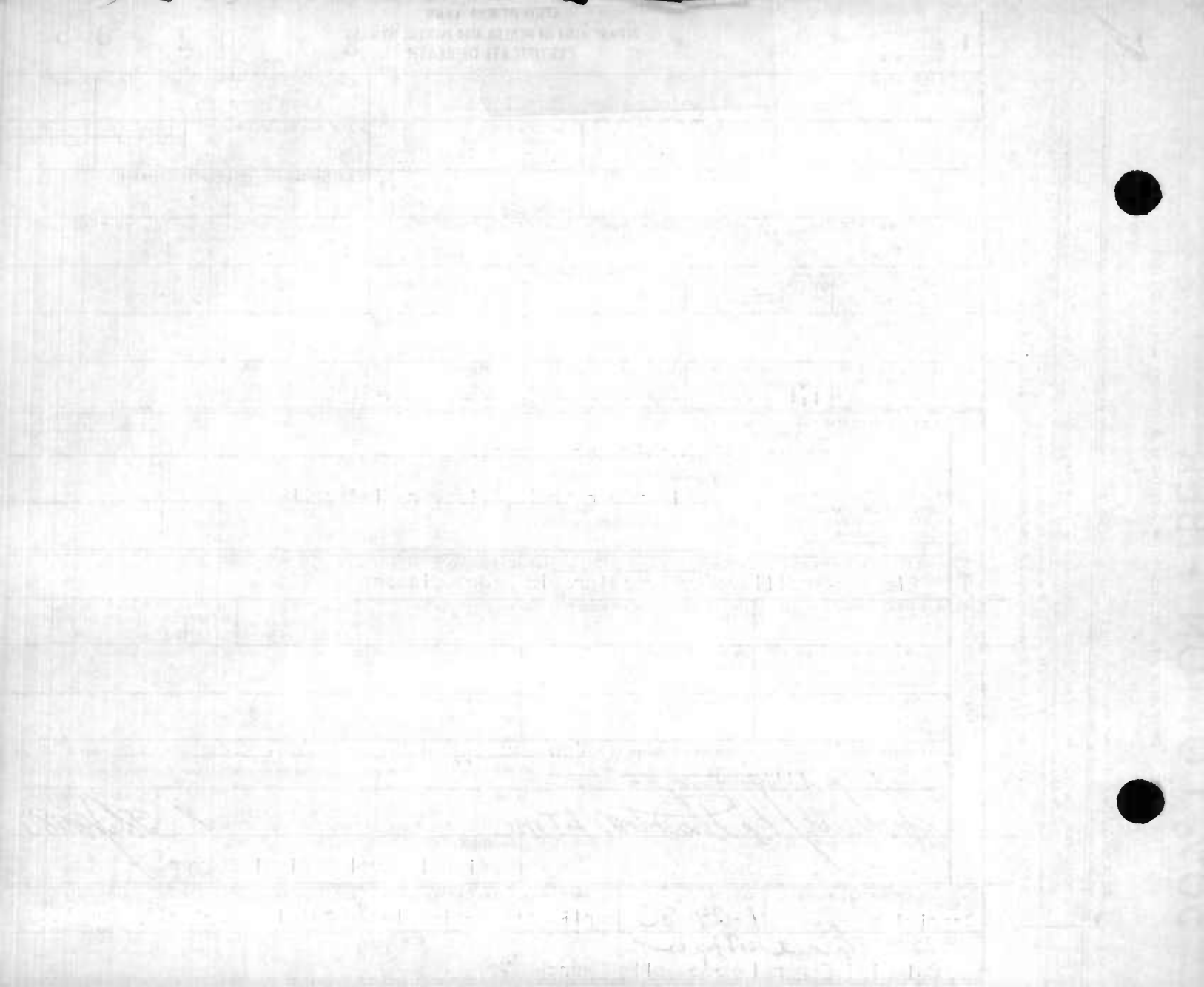
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |  |  |
|---|--|--|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8002088   |   |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR                                     |
| Richard Melvin Mayfield   |  |  |   |  |  | January 25 1980  |   |  | 7:35p M                                      |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR IF UNDER 24 HRS                                |  |
| Male  |  | Caucasian  |   | July 8 1929  |  | 50   |   | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Kansas  |  | USA  |   |  |  | Montgomery County MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda  |  | National Naval Medical Center  |   |  |  | USAIR Force  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                     |  |  |
| 13a. STATE 13b. COUNTY Virginia Fairfax   |  |  |   |  | 13c. CITY OR TOWN Reston YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 11232 Chestnut Grove Sq. #133           |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |
| Orley Mayfield  |  |  |   |  | Mildred Hicks  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |  |
| yes   |  |  | 1945-1967   |  | 509-20-5925 Doris E. Mayfield See Above  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>   |  |  |   |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Right cerebral hemisphere infarction</u>  |  |  |   |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |   |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |   |  |  |
| Diabetes mellitus/Atherosclerotic heart disease   |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| None  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
|   |  |  | P.M. 19   |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |
|   |  |  |   |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 18 19 80, to Jan. 25 19 80, that (I) (we) lost saw the deceased alive on Jan. 25 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE  |  |  |   |  | DEGREE   |  |   | 22c. DATE SIGNED   |  |
| Andrew J. Dutka, M.D.   |  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 28 Jan 80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS   |  |   |  |  |
| Andrew J. Dutka, M.D.   |  |  |   |  | National Naval Medical Center, Bethesda, Md.   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |
| Cremation   |  |  | 1-29-80   |  | Cedar Hill Crematory   |  | Suitland Prince George Md.              |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |   |  | 24b. ADDRESS   |  | 25a. DATE REC'D BY REGISTRAR            |  | 25b. REGISTRAR'S SIGNATURE                   |
| Colonial Funeral Home Falls Church, Va.   |  |  |   |  |  |  | JAN 31 1980                             |  |  |

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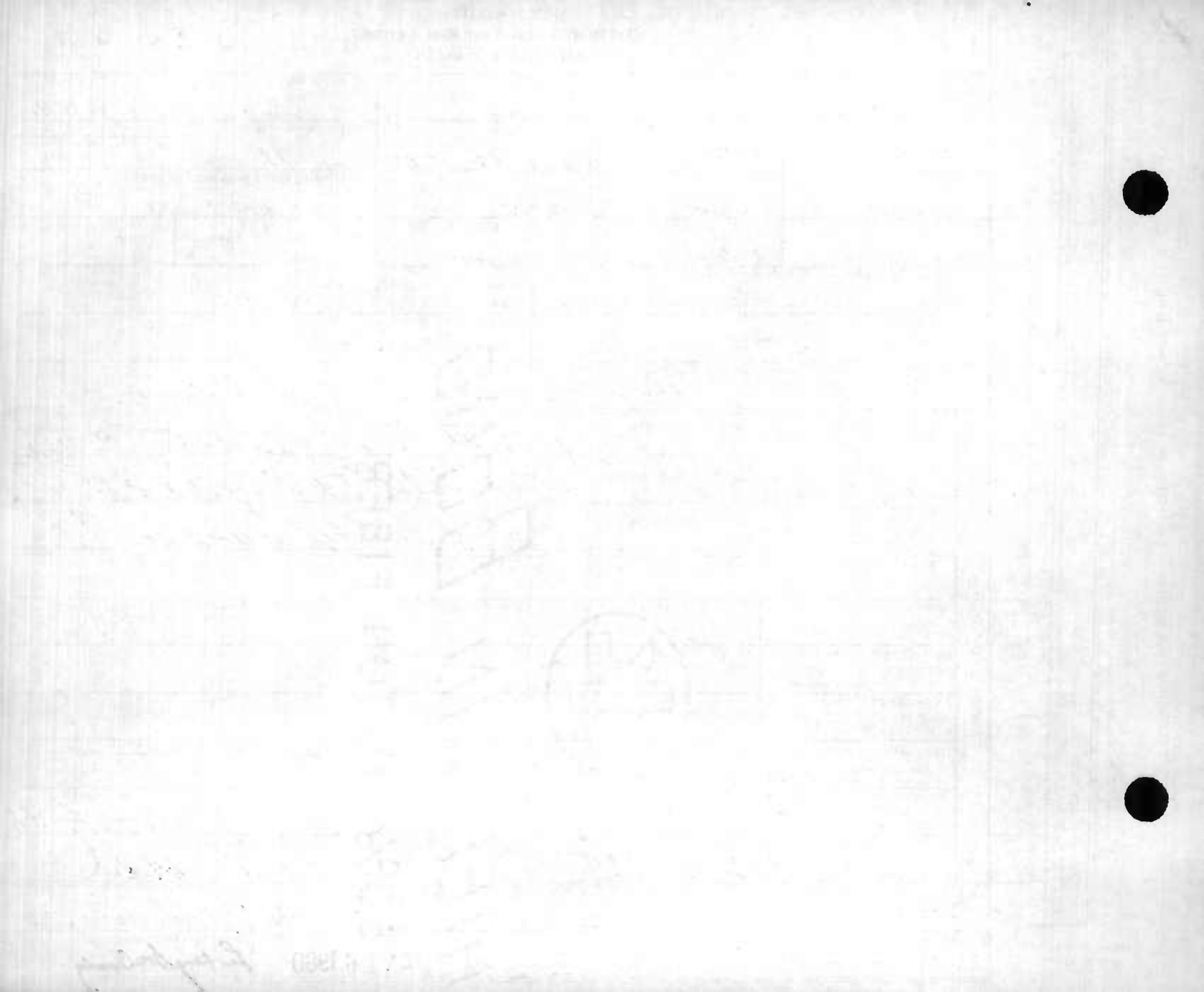
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |   |  |
|---|--|--|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | REG. NO. 8002089   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Julia Davis McCloskey</i>  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><i>January 13, 1980 1:20 A.M.</i> |  |   |   |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>May 19 1887</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>92</i>   |   | 7 IF UNDER 1 YEAR IF UNDER 74 HRS.<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>The Colonial Villa Nursing Home</i> |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Teacher</i> |  | 12b KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a STATE<br><i>Maryland</i>  |  | 13b COUNTY<br><i>Montgomery</i>  |   | 13c CITY OR TOWN<br><i>Silver Spring</i>   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS<br><i>21 Shaw Ave.</i>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Edmund C. Davis</i>   |  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Lydia A. Green</i>             |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b SOCIAL SECURITY NO.<br><i>220-12-3280</i>  |   | 17 INFORMANT ADDRESS<br><i>Benjamin C. Shaw 21 Shaw Ave. Silver Spring, Md. 20904</i>  |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Coronary Disease</i> (b) <i>Grand Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>2 weeks</i> (c) <i>5 yrs</i>   |  |  |   |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>         |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/27/76</i> 19 <i>80</i> to <i>Jan 13</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>Jan 13</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |   |  |
| 22b. SIGNATURE DEGREE<br><i>L.W. Mahin M.D.</i>   |  |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>1-13-80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>L.W. MAHIN M.D.</i>   |  |  |   |  |  | 22e. ADDRESS<br><i>Brentwood, Md.</i>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>Jan. 15, 80</i>                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ft. Lincoln Cemetery</i>              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Brentwood, Prince George, Md.</i> |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Hines/Rinaldi Funeral Home</i>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 16 1980</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Henry A. Brady</i>   |  |

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 0 2 0 9 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>JENNIE E. McDowell</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1-12-80</i>                                   |  | 2b. HOUR<br><i>2:AM</i>  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Caucasian</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Mar. 27, 1883</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>96</i> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Canada</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Fernwood House</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Montgomery</i>   | 13c. CITY OR TOWN<br><i>Chevy Chase</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Thomas Dunlop</i>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Letitia Savage</i>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>532-28-4725</i>  |  | 17. INFORMANT ADDRESS<br><i>George E. McDowell, Same as #13</i>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i><br><i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 mo.</i><br><i>20 YRS.</i> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><i>12/31/79</i> <i>1/12/80</i>     |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>12/31/79</i> to <i>1/12/80</i> that (1) (we) lost saw the deceased alive on <i>12/31/79</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Henry C. Scruggs, M.D.</i>  |  | DEGREE  |  | 22c. DATE SIGNED<br><i>1/12/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Henry C. Scruggs, M.D.</i>   |  | 22e. ADDRESS<br><i>5413 W. Cedar Lane Bethesda, Maryland</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |  | 23b. DATE<br><i>1/15/80</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Metropolitan Crem.</i>                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Alexandria, Virginia</i>   |
| 24. FUNERAL DIRECTOR NAME<br><i>Robert A. Punphrey Funeral Homes, P.A. Bethesda, Maryland</i>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 16 1980</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry C. Scruggs</i>  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

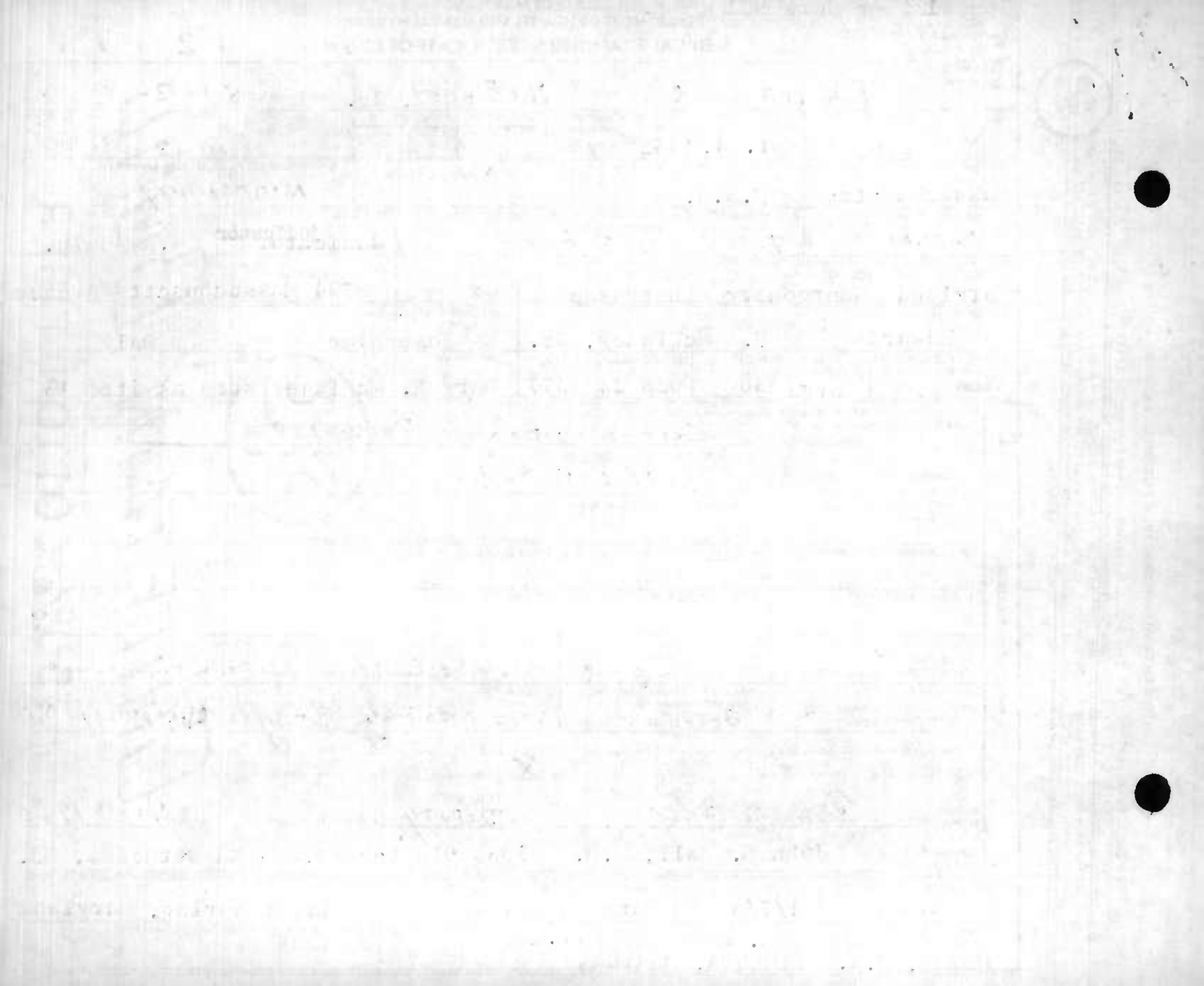
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Item #22a per phone call w/Fun. Home STATE OF MARYLAND  
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 1- STATE 1/7/80 rc  
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

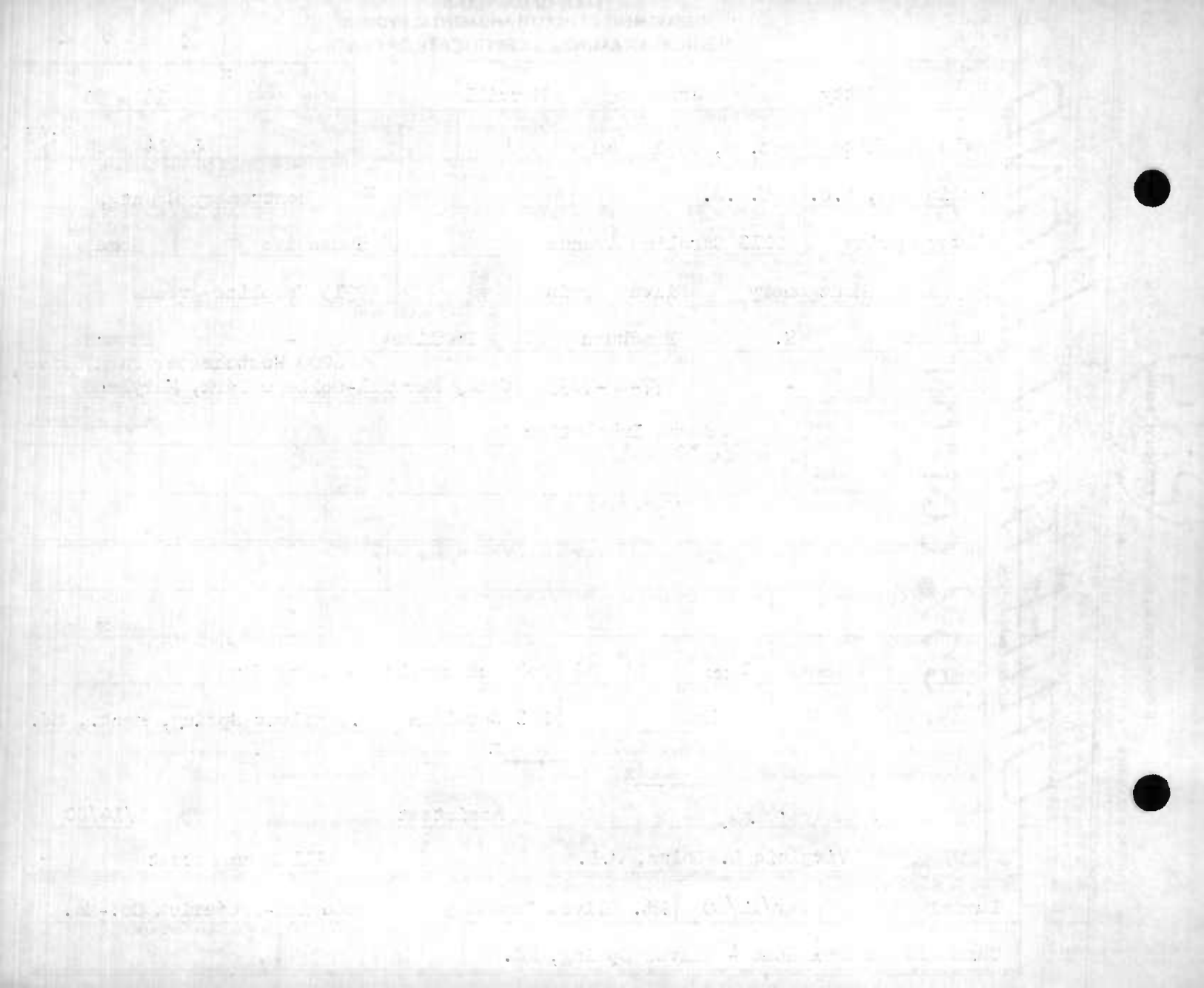
REG. NO. 02091

|   |         |  |  |  |                |   |                  |                       |                          |
|---|---------|--|--|--|----------------|---|------------------|-----------------------|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST MIDDLE LAST  |  | 2a. DATE KNOWN OF DEATH  |                | MONTH DAY YEAR  |                  | 2b. HOUR              |                          |
| Edward  |         | McElaney, Jr.  |  | 1-3-1980   |                |   |                  | PM                    |                          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  | IF UNDER 1 YR. |   | IF UNDER 24 HRS. |                       | 7c. DATE PRONOUNCED DEAD |
| M   | W       | Apr. 4, 1932   |  | 47 YRS.  |                |   |                  |                       | Jan 3 1980               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |                       |                          |
| Massachusetts   |         | U.S.A.   |  |  |                | Montgomery MD.  |                  |                       |                          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |                       |                          |
| Bethesda  |         | 5704 Mass. Ave.  |  | Judicator  |                | VA Admin.   |                  |                       |                          |
| 13a. STATE  |         | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |                | 13e. STREET ADDRESS   |                  |                       |                          |
| Maryland  |         | Montgomery   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                | 5704 Massachusetts Avenue   |                  |                       |                          |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                | 16b. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS |                          |
| Edward  |         | C. McElaney, Sr.   |  | Josephine  |                | Daly  |                  | Yes                   |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                | 20. AUTOPSY?  |                  |                       |                          |
| PART I DEATH WAS CAUSED BY:   |         |  |  |  |                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |                       |                          |
| IMMEDIATE CAUSE (a)   |         |  |  |  |                |   |                  |                       |                          |
| 9520  |         |  |  |  |                |   |                  |                       |                          |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                |   |                  |                       |                          |
| (b)   |         |  |  |  |                |   |                  |                       |                          |
| Self Inflicted -  |         |  |  |  |                |   |                  |                       |                          |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                |   |                  |                       |                          |
| (c)   |         |  |  |  |                |   |                  |                       |                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |  |  |  |                |   |                  |                       |                          |
| 21a. EXTERNAL CAUSE WAS   |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                |   |                  |                       |                          |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                              |         | 7 P.M. 1-3-1980  |  | Inhalation exhaust fumes from car in closed garage.  |                |   |                  |                       |                          |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |                |   |                  |                       |                          |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         | Garage.  |  | 5704 Mass Ave. Bethesda Montgomery Md.   |                |   |                  |                       |                          |
| 22a. I certify that I took charge of the remains described above, held on   |         | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion  |  |  |                |   |                  |                       |                          |
| death resulted from:  |         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |                |   |                  |                       |                          |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |  | MEDICAL EXAMINER   |                | DATE SIGNED   |                  |                       |                          |
| John G. Ball  |         | M.D. Deputy  |  |  |                | Jan 3, 1980   |                  |                       |                          |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | 7936 Old Georgetown Rd Bethesda, Md.   |  |  |                |   |                  |                       |                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                | 23d. LOCATION   |                  |                       |                          |
| Burial  |         | 1/7/80   |  | Gate of Heaven   |                | Silver Spring, Maryland   |                  |                       |                          |
| 24. FUNERAL DIRECTOR NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                |   |                  |                       |                          |
| ROBERT A. HUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND   |         | JAN 7 1980   |  |  |                |   |                  |                       |                          |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  |             |  |  |  |   |  |   |  |                  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                     |  | REG. NO. 0 2 0 9 2                   |  |      |  |          |  |            |  |
|--|--|-------------|--|--|--|---|--|---|--|------------------|--|--|--|-------------------------------------|--|--------------------------------------|--|------|--|----------|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |             |  |  |  | FIRST   |  | MIDDLE  |  | LAST             |  | 2a. DATE KNOWN<br>OF DEATH   |  | ESTI-<br>MATED                      |  | MONTH                                |  | DAY  |  | YEAR     |  | 2b. HOUR   |  |
| Betty  |  |             |  |  |  | Jane  |  | Merrill   |  |                  |  |  |  | <input checked="" type="checkbox"/> |  | 1                                    |  | 14   |  | 19       |  | 80         |  |
| 3. SEX   |  | 4. RACE     |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | MONTH                               |  | DAY                                  |  | YEAR |  | 2d. HOUR |  |            |  |
| Female   |  | White       |  | Oct. 6, 1931   |  | 48 YRS.   |  |   |  |                  |  |  |  | 1                                   |  | 14                                   |  | 19   |  | 80       |  | 7:45<br>AM |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  |             |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Washington, D.C.   |  |             |  | U.S.A.   |  |   |  |   |  |                  |  | Montgomery County, MD  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 10. CITY OR TOWN OF DEATH  |  |             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                   |  |                                     |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |      |  |          |  |            |  |
| Silver Spring  |  |             |  | 9313 Caroline Avenue   |  |   |  |   |  |                  |  | Housewife  |  |                                     |  | Home                                 |  |      |  |          |  |            |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 13a. STATE   |  | 13b. COUNTY |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Maryland   |  | Montgomery  |  | Silver Spring  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 9315 Caroline Avenue  |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 14. FATHER'S NAME  |  |             |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| FIRST  |  | MIDDLE      |  | LAST   |  | FIRST   |  | MIDDLE  |  | LAST             |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Herbert  |  | E.          |  | Bradburn   |  | Pauline   |  |   |  | Thomas           |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  |   |  | 17. INFORMANT   |  |                  |  | 6200 Westchester Park Drive  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| No   |  |             |  | -  |  |   |  | 577-42-7035   |  |                  |  | Cathy Merrill-College Park, Maryland   |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |             |  |  |  |   |  |   |  |                  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                    |  |                                     |  |                                      |  |      |  |          |  |            |  |
| PART I DEATH WAS CAUSED BY: <u>Smoke Inhalation</u>  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| IMMEDIATE CAUSE (a) <u>8902</u>  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| (b)  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| (c)  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 19a. DATE OF OPERATION   |  |             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                  |  | 20. AUTOPSY?   |  |                                     |  |                                      |  |      |  |          |  |            |  |
|  |  |             |  |  |  |   |  |   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? <del>20</del> 1 14 1980                               |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
|  |  |             |  |  |  |   |  | Subject caught in house fire  |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |             |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home                                     |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>9313 Caroline Ave., Silver Spring, Mont., Md.  |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |             |  |  |  |   |  |   |  |                  |  |  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| ACTUAL<br>SIGNATURE  |  |             |  | Virginia L. Dolan M.D.   |  |   |  | TITLE (SPECIFY)<br>Assistant  |  |                  |  | DATE<br>SIGNED 1/14/80   |  |                                     |  |                                      |  |      |  |          |  |            |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |             |  | Virginia L. Dolan, M.D.  |  |   |  | ADDRESS   |  |                  |  | 111 Penn Street  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |             |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Burial   |  |             |  | Jan/18/80  |  |   |  | Mt. Olivet Cemetery   |  |                  |  | Frederick-Frederick Co.-Md.  |  |                                     |  |                                      |  |      |  |          |  |            |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |             |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |                  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                     |  |                                      |  |      |  |          |  |            |  |
| Chambers Funeral Home - Silver Spring, Md.   |  |             |  |  |  |   |  | JAN 23 1980   |  |                  |  | Turkey McCready  |  |                                     |  |                                      |  |      |  |          |  |            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 8 0 0 2 0 9 3      |  |                  |  |
|--|--|---|--|---|--|--|--|--|--|-----------------------------|--|------------------|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR  |  |  |  |                             |  | 2b HOUR          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Louise N. Michaelsen</b>  |  |   |  |   |  | <b>Jan 1, 1980</b>   |  |  |  |                             |  | <b>1:45 P.M.</b> |  |
| 3 SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>July 10, 1897</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |  |  |                             |  |                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rockville Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |                             |  |                  |  |
| 13a. STATE<br><b>Virginia</b>  |  | 13b. COUNTY<br><b>Fairfax</b>   |  | 13c. CITY OR TOWN<br><b>Mc Lean</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1235 Colonial Road</b>   |  |                             |  |                  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>William L. Nicholson</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice Mae Ramey</b>   |  |  |  |                             |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>not known</b>  |  | 17 INFORMANT<br><b>George J. Black</b>  |  | ADDRESS<br><b>1235 Colonial Road<br/>Mc Lean, Virginia</b>   |  |  |  |                             |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u><br>431-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis + Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 Hours</u><br><u>5 years</u> |  |   |  |   |  |  |  |  |  |                             |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |                             |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                             |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                             |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 28</u> , 19 <u>78</u> , to <u>Jan 1</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Jan 1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |                             |  |                  |  |
| 22b. SIGNATURE<br><u>C. R. Gruver</u> MD   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1/1/80</u>  |  |                             |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. R. Gruver, M. D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>1145 - 19th St., N. W., Washington, D. C.</b>   |  |  |  |                             |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan 2, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Prince Georges, Md.</b>   |  |  |  |                             |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>  |  | ADDRESS<br><b>5130 Wisconsin Ave., N. W.</b>  |  | DATE REC'D. BY REGISTRAR<br><b>JAN 8 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |                             |  |                  |  |



C. R. . . .  
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |  |  |   |   |
|---|--|--|---|--|---|--|--|---|---|
| 1- FOR STATE REGISTRAR  |  |  |   |  |   |  |  |   |   |
| REG. NO. 8002094  |  |  |   |  |   |  |  |   |   |
| 1 DECEASED NAME (TYPE OR PRINT)<br>RUTH B. MIDDLETON  |  |  | 2a DATE OF DEATH<br>MONTH 1 DAY 12 YEAR 80                            |  |   | 2b HOUR<br>6:45 A M  |  |   |   |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH 1 DAY 11 YEAR 95  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |   |   |
| 10 CITY OR TOWN OF DEATH<br>SILVERSPRING  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hosp. |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |   |  |  |   |   |
| 13a STATE<br>Md.  |  | 13b COUNTY<br>Montgomery   |   | 13c CITY OR TOWN<br>Silver Spring  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>8505 Springvale Rd.   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred Bache   |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Richardson          |  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b SOCIAL SECURITY NO.<br>370-07-4154                                |  | 17 INFORMANT ADDRESS<br>Wash.<br>Betty M. Geisler 1651 34th St. N.W. D.C.     |  |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Left Middle Cerebral Artery Occlusion<br>4349<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                       |  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |   |  |  |   |   |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |   |
| 22a I certify that (I) (the hospital) attended the deceased from 12/14/75 to 1-11-80, that (I) (we) saw the deceased alive on 1-11-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |  |   |   |
| 22b SIGNATURE<br>Hubert J. Alpert, M.D.   |  |  |   |  | DEGREE<br>M.D.  |  |  | 22c DATE SIGNED<br>JAN. 12, 1980  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>HUBERT J. ALPERT, M.D.  |  |  |   |  | 22e ADDRESS<br>8630 FENTON ST.<br>SILVER SPRING, MD 20910                     |  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  | 23b DATE<br>1-14-80  |   | 23c NAME OF CEMETERY OR CREMATORY<br>George Wash. U. Med. School, Wash. D. C.  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 23e DATE REC'D. BY REGISTRAR  |   |
| 24 FUNERAL DIRECTOR<br>NAME Metropolitan F S 5517 Vine St.<br>Alexandria, Va.   |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 16 1980                                   |  | 25b REGISTRAR'S SIGNATURE<br>[Signature] |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 0 9 5  
REG. NO.

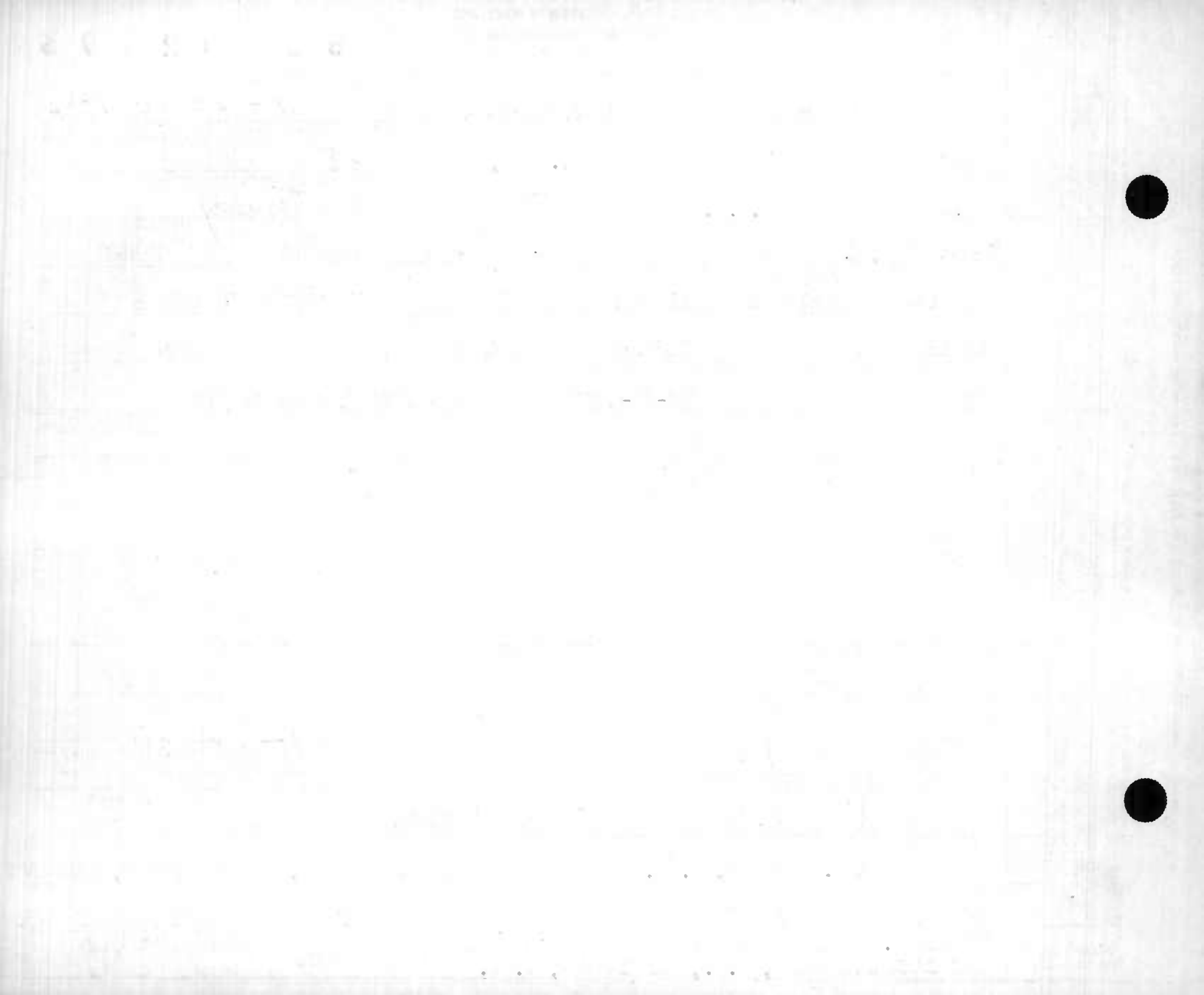
|  |  |   |   |   |   |   |  |
|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Samuel Milewsky</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-22-80</b> |   | 2b. HOUR<br>MIN AM PM<br><b>1:20 AM</b> |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 16, 1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>68</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>MERCHANT</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GROCER</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEWIS</b>                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH KAHN</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>062-24-8828A</b>                                    |  | 17. INFORMANT<br>ADDRESS<br><b>SADIE MILEWSKY, same as #13</b>  |   |   |   |   |  |

|   |  |   |  |
|---|--|---|--|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>436-</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>80/2/25</b> 19 <b>79</b> to <b>1-22</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1-22</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Carroll D. Mahoney</b> DEGREE <b>M.D.</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-22-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARROLL D. MAHONEY, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>10301 GEORGIA AVENUE, SILVER SPRING, MARYLAND</b>   |  |  |  |

|  |  |                               |  |   |  |   |  |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                      |  | 23b. DATE<br><b>1/23/1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ADELPHI PRINCE GEORGES MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C.  |  |                               |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |                                    |  |  |   |  | 8 0 0 2 0 9 6   |          |                     |  |
|--|--|---|--|---|------------------------------------|--|--|---|--|---|----------|---------------------|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |                                    |  |  |   |  | REG. NO.  |          |                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST  |   |                                    | 2a. DATE OF DEATH  |  |   | MONTH DAY YEAR                           |   | 2b. HOUR |                     |  |
| Elmer F Mills  |  |   |  |   |                                    | January 7, 1980  |  |   | 2:15 A.M.                                |   |          |                     |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |          |                     |  |
| Male   |  | White   |  | January 11 1908   |                                    | 71 YRS.  |  | MONTHS DAYS   |  | HOURS MIN   |          |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |          |                     |  |
| Wash. D.C.   |  | U.S.A.  |  |   |                                    | Montgomery MD.   |  |   |  |   |          |                     |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |   |          |                     |  |
| Takoma Park  |  | Washington Adventist Hospital   |  |   |                                    | Cab Driver   |  | Taxi  |  |   |          |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13b. COUNTY  |   |                                    | 13c. CITY OR TOWN  |  |   | 13d. INSIDE CITY LIMITS?                 |   |          | 13e. STREET ADDRESS |  |
| Maryland   |  |   | Pr. George's   |   |                                    | Hillcrest Hgts   |  |   | NO <input type="checkbox"/>              |   |          | 2302 Kirby Drive    |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |   |                                    |  |  |   |  |   |          |                     |  |
| Frank Mills  |  |   | Mary A. Feister  |   |                                    |  |  |   |  |   |          |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT  |  |   | ADDRESS                                  |   |          |                     |  |
| No   |  |   | 216-40-5108  |   |                                    | Ruby T. Jones  |  |   | 10091 Wash., Blvd.#9<br>Laurel, Maryland |   |          |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Squamous Cell Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Bronchitis</u><br>1991 |  |   |  |   |                                    |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 min |          |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |  |   |                                    |  |  |   |  |   |          |                     |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |   |          |                     |  |
|  |  |   |  |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |          |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |          |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |          |                     |  |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 1979 to 7:50 AM 1980, that (I) (we) last saw the deceased alive on 12/6/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.  |  |   |  |   |                                    |  |  |   |  |   |          |                     |  |
| 22a. SIGNATURE<br>VITOMAS A. BENSINGER   |  |   |  |   |                                    | DEGREE<br>MD   |  | 22b. ADDRESS<br>831 University Blvd E. S. 1 Spg MD 20903          |  | 22c. DATE SIGNED<br>1/7/80                                |          |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |   |          |                     |  |
| Burial   |  |   | 1/9/80   |   | Mt. Olivet Cemetery                |  | Washington, D. C.                          |   |  |   |          |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME George P. Kalas   |  |   |  |   |                                    | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |          |                     |  |
| 6160 Oxon Hill Rd, Oxon Hill, Maryland   |  |   |  |   |                                    | JAN 10 1980  |  | [Signature]   |  |   |          |                     |  |

George A. Nelson, Treasurer  
Owen Hall, Secretary

Washington, D. C.

1918-1919

July 1, 1918

Walter  
George A. Nelson, Treasurer  
Owen Hall, Secretary

Frank

Wife

Very

Wife

Wife

Wife

Wife

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TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

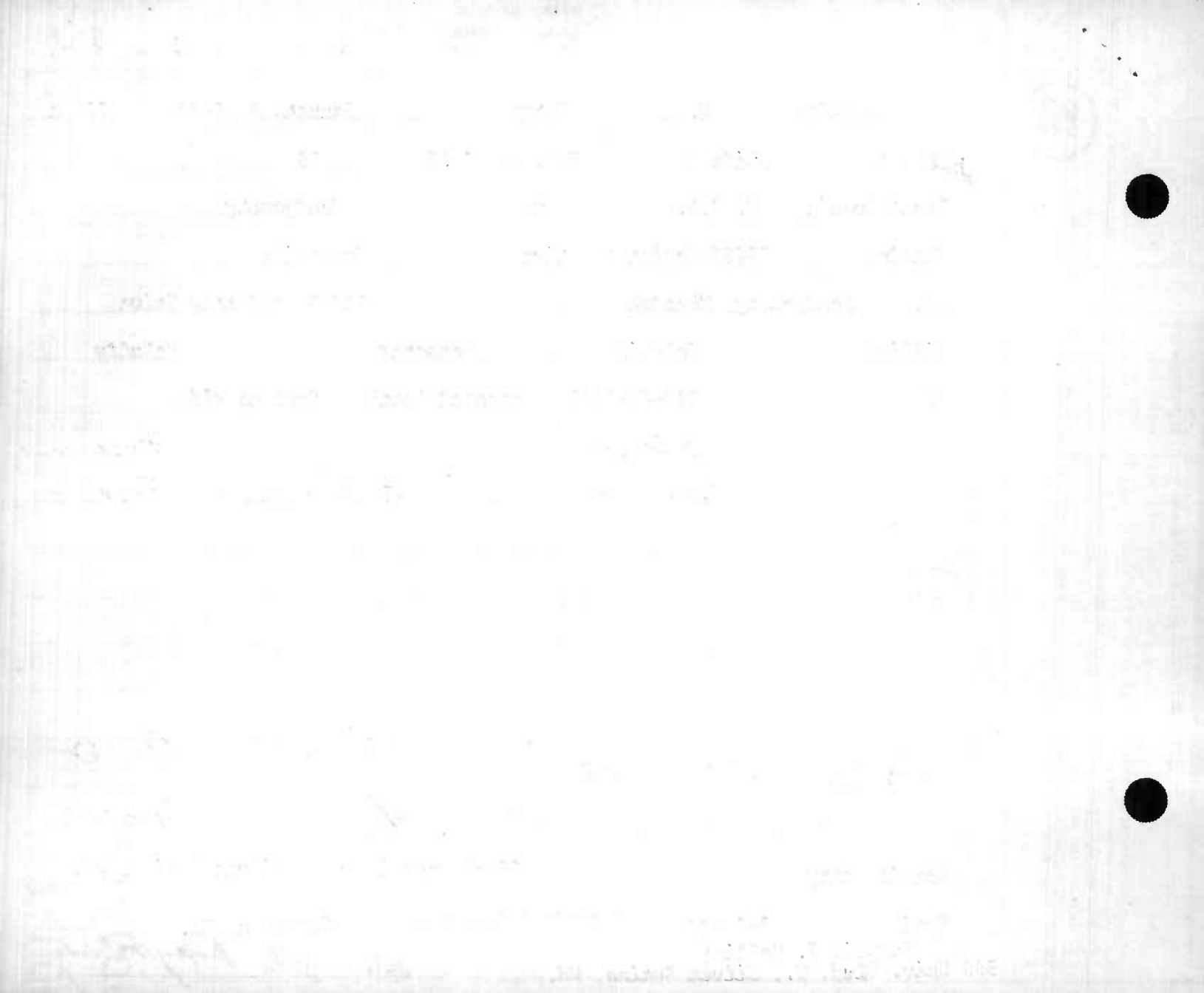
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |                            | REG. NO. 8002097   |  |
|---|--|--|--|--|--|--|--|--|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Josephine M. Moran</i>  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>January 8, 1980</i>                           |  |  | 2b. HOUR<br><i>11 a.m.</i> |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Feb. 28, 1903</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS.                                    |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |                            | 7. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                        |  |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Wheaton</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>11433 Monterrey Drive</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                            |  |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Wheaton</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>11433 Monterrey Drive</i>  |                            |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Dolphin</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Margaret McNulty</i>  |  |  |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-44-9441</i>   |  | 17. INFORMANT ADDRESS<br><i>Margaret Lerch Same as #13</i>   |  |  |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Stroke</i><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Generalized Cerebral Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 years</i><br><i>5 years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |                            |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                            |  |  |
| 22. I certify that (1) this hospital attended the deceased from <i>May 19 1977</i> to <i>1-8</i> 19 <i>80</i> , that (1) (we) last saw the deceased alive on <i>1-6</i> 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.   |  |  |  |  |  |  |  |  |                            |  |  |
| 22a. SIGNATURE<br><i>Morris Perry</i>   |  |  |  | DEGREE <i>MD</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><i>1-8-80</i>  |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Morris Perry</i>  |  |  |  | 22e. ADDRESS<br><i>11602 Georgia Ave., Silver Spring, Md.</i>  |  |  |  |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1-10-80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cathedral Cemetery</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Scranton Pa.</i>                       |  |  |                            |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Francis J. Collins</i>  |  |  |  |  |  | ADDRESS<br><i>500 Univ. Blvd. W., Silver Spring, Md.</i>                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1980</i>   |                            | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McNulty</i>                             |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8002098

FOR  
1 - STATE  
REGISTRAR

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward Leroy Murphy</b>   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 15, 1980</b>          |  | 2b. HOUR<br><b>5:11pm</b>  |
| 3 SEX<br><b>MAle</b>   | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 18, 1924</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.         |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |   |  | 13b. COUNTY<br><b>Montg.</b>   | 13c. CITY OR TOWN<br><b>BRIGHTON</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLIE MURPHY</b>   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BETTIE MURPHY</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   | 17 INFORMANT<br>ADDRESS<br><b>Bettie Murphy (Mother) Bait. Md.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiogenic shock</b><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acute anteroseptal myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hours</b><br><b>6 hours</b> |   |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1980</b> to <b>Jan 15, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 15, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did not view the body after death.   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Mark S. Rosen MD</b>  |   | DEGREE   |  | 22c. DATE SIGNED<br><b>1/15/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK S. ROSEN, M.D.</b>  |   | 22e. ADDRESS<br><b>1131 University Blvd. W. Silver Spring Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   | 23b. DATE<br><b>1-19-80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAISY Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodbine Howard Md.</b>             |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>  |   | 24b. ADDRESS<br><b>246 N. Wash. St. Rockville, Md.</b>   |  | 25a. DATE RECEIVED BY REGISTRAR (25b. REG. NO.)<br><b>JAN 21 1980</b>                |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                       |   |  |
|--|--|--|--|---|--|--|-----------------------|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |  |                       |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Helen Frances Murphy  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 28 1980        |  | 2b. HOUR<br>1:30 P.M. |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Cauc.  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 27 20  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |                       | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                 |                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12121 Kerwood Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |                       | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |                       |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       | 13e. STREET ADDRESS<br>12121 Kerwood Road   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Francis White   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jane Gunning |  |                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>139-12-5513  |  | 17. INFORMANT ADDRESS<br>Same as above<br>Carroll Murphy (Husband)  |  |  |                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Colorectal Carcinoma (9-77)</u><br>1540<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |   |  |  |                       |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION  |  |  |  |   |  |  |                       |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                       |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                       |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 3, 19 80</u> to <u>JANUARY 28, 19 80</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 3, 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |                       |   |  |
| 22b. SIGNATURE<br>Richard W. Holt MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |                       | 22c. DATE SIGNED<br>1-28-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard W. Holt, M.D.   |  |  |  | 22e. ADDRESS<br>3800 Reservoir Road, N.W. Wash. D.C. 20007  |  |  |                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/31/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>S.S. Mont. Md.                                    |                       |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>R. Hines   |                       |   |  |

WATER

WATER

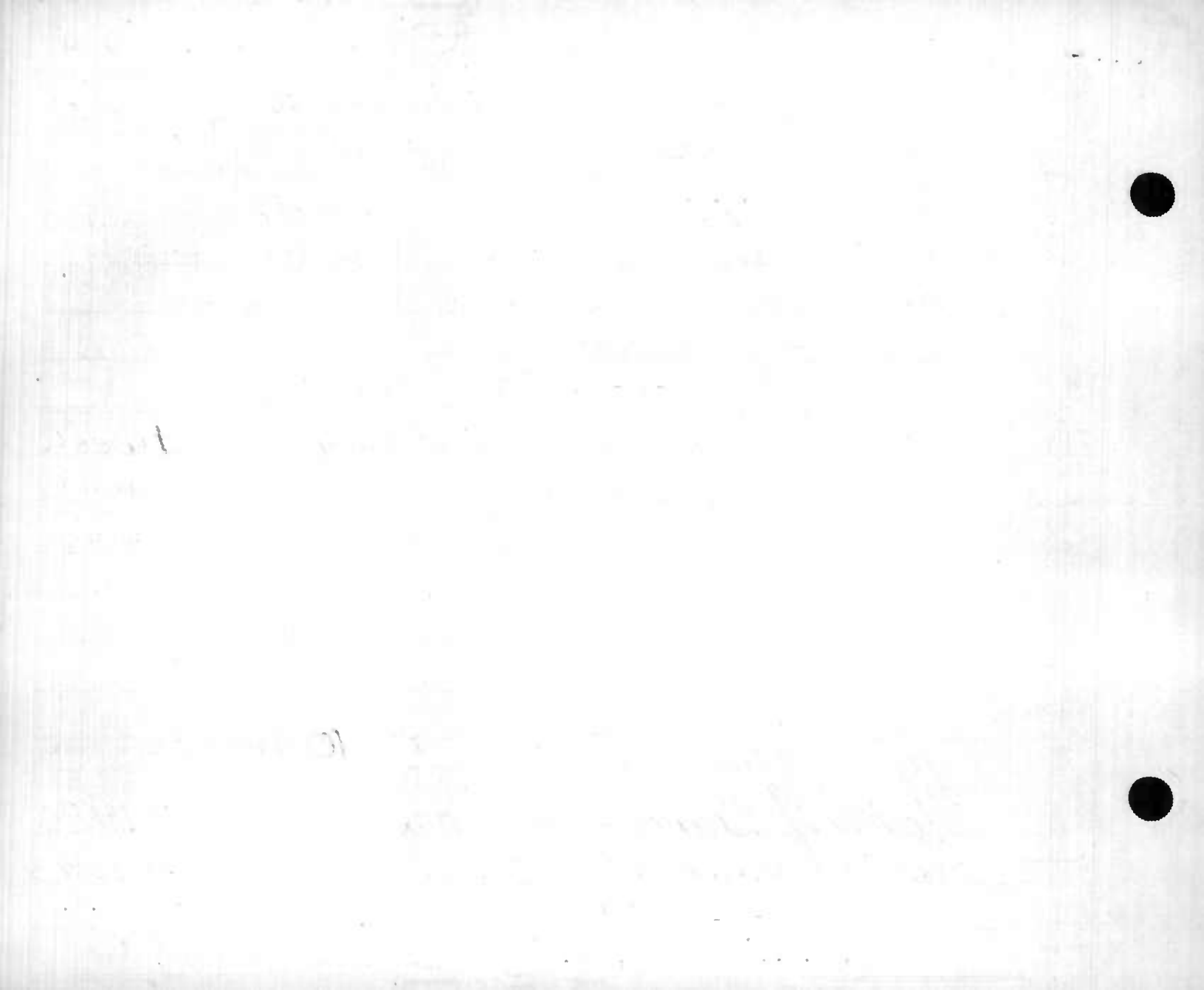
10-32-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |   | 8002100                     |  |  |  |
|---|--|--|--|---|---|---|--|--|---|-----------------------------|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |   |   |  |  |   | REG. NO.                    |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>Russell H Nanfelt Jr.</b>  |  |  |  |   | 2a DATE OF DEATH MONTH DAY YEAR <b>1-10-80</b>  |   |  |  | 2b HOUR <b>3:10 PM</b>  |                             |  |  |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>6 15 45</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS                                |   | IF UNDER 24 HRS. HOURS MIN. |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montg.</b> MD.                         |  |  |   |                             |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adventist Hosp</b> |  |   |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>         |   |                             |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13b STREET ADDRESS <b>115 Meem Ave.</b>  |  |   |                             |  |  |  |
| 13a STATE <b>MD</b>   |  | 13b COUNTY <b>Montg.</b>   |  | 13c CITY OR TOWN <b>Gaithersburg</b>  |   |   |  |  |   |                             |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Russell H. Nanfelt Sr.</b>  |  |  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Counihan</b>                           |   |  |  |   |                             |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |   | 16b SOCIAL SECURITY NO <b>214-48-6451</b>   |   | 17 DECEASED'S NAME (Same as 13c) <b>Daniel Nanfelt</b>                           |  |   |                             |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary &amp; Intestinal</b><br>1729 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Tuberculosis</b><br>3 months }<br>(c) <b>Melanotic Melanoma</b><br>11 months }<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b> |  |  |  |   |   |   |  |  |   |                             |  |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9 25 79</b>         |   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |                             |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |                             |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>9 JAN 80</b> to <b>10 JAN 80</b> , that (I) (we) lost <b>EC</b> the deceased alive on <b>9 JAN 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <b>9 JAN 80</b>  |  |  |  |   |   |   |  |  |   |                             |  |  |  |
| 22b SIGNATURE <b>Thomas A. Bensinger</b> DEGREE <b>MD</b>   |  |  |  |   | 22c DATE SIGNED <b>10 JAN 80</b>  |   |  |  |   |                             |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS A. BENNINGER, MD</b>   |  |  |  |   | 22e ADDRESS <b>831 Univ Blvd E. Sil Spg MD 20903</b>  |   |  |  |   |                             |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  | 23b DATE <b>1-14-80</b>  |   | 23c NAME OF CEMETERY OR CREMATORY <b>Birchwood Annex Cem.</b>                               |   |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Roxboro N.C.</b> |   |                             |  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>Robert A. Humphrey</b> ADDRESS <b>Homes, P.A., Bethesda, Md.</b>  |  |  |  |   | 25a DATE REC'D. BY REGISTRAR <b>JAN 16 1980</b>   |   |  | 25b REGISTRAR'S SIGNATURE <b>Dorothy M. Lindsey</b>        |   |                             |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                     |  |  |   |   |   |  |  |                             |   |   | REG. NO. 02101  |  |                          |  |
|--|---------------------|--|--|---|---|---|--|--|-----------------------------|---|---|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Harry W. Neben</b>   |                     |  |  |   |   |   |  |  |                             |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>1-17-80</b> |  | 2b. HOUR<br><b>34 PM</b> |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-15-95</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>84</b> YRS.                      | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0</b> <b>0</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0</b> <b>0</b>   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-17-80</b> |  | 2d. HOUR<br><b>12:34 PM</b> |   | 2e. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont.</b> MD. |   |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUSETTS</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>        |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  |                             |   |   |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Wash DC</b>  |                     |  |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b>          |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED MASTER ELECTRICIAN</b> |                             |   | 12b. KIND OF BUSINESS OR INDUSTRY                         |   |  |                          |  |
| 13a. STATE<br><b>DC</b>  |                     | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Washington</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1825 Columbia Rd NW</b>  |                             |   |   |   |  |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August NEBEN</b>  |                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SOPHIA PFERDEKAMP</b> |   |   |  |  |                             |   |   |   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>W.W.I</b>             |  | 17. INFORMANT<br><b>Mrs. P. Hertz</b>                                     |   | ADDRESS<br><b>FITCHBURG, MA</b>   |  |  |                             |   |   |   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>4291</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                     |  |  |   |   |   |  |  |                             |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>None</b>   |                     |  |  |   |   |   |  |  |                             |   |   |   |  |                          |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                     |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |   |   |  |  |                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |                             |   |   |   |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                             |   |   |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |  |  |   |   |   |  |  |                             |   |   |   |  |                          |  |
| ACTUAL SIGNATURE<br><b>John P. Regan</b>   |                     |  |  | TITLE (SPECIFY)<br><b>M.D. Dip</b>  |   |   |  | DATE<br><b>Jan 18 1980</b>   |                             |   |   | DATE<br><b>Jan 18 1980</b>  |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                     |  |  | ADDRESS   |   |   |  |  |                             |   |   |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |                     | 23b. DATE<br><b>1-21-79</b>                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY</b>       |   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VA</b>                                 |                             |   |   |   |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>METROPOLITAN FUNERAL SER ALEXANDRIA</b>   |                     |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>5517 VINE ST</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jan 24 1980</b>  |  |  |                             |   |   |   |  |                          |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

1-17-61 11:34 AM

Heber

W.

Henry

1-17-61 11:34 AM

Heber

Washington A. Venturi

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |  |  |  |   |  | REG. NO. 0 2 1 0 2   |  |
|--|-------------------------|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Bernice Hammond Nelson</b>   |                         |  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 27 19 80</b> |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 9, 1924</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>55</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>1 27</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19 80</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 27 19 80</b>                      |  | 2d. HOUR<br><b>8:05 P M</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13920 Georgia Avenue (in parking lot)</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Montg.</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>10100 New Hampshire Ave. #210</b>                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac W. Ellison</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mildred F. Johnson</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-12-2783</b>   |  | 17. INFORMANT ADDRESS<br><b>Lorraine Morrison (Daughter) 5016 Tuckerman Riverdale, Md.</b>  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029 Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>IMMEDIATE CAUSE (a) <b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)   |                         |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D.   |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/28/80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |                         |  |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2-2-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ash Memorial Cemetery</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sandy Spring, Montg. Md.</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>   |                         |  |  | 24b. ADDRESS<br><b>246 N. Washington Street Rockville, Md. 20850</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1980</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McCready</b>  |  |

US ARMY - GADSDEN AND WASHINGTON  
MAIL - ROCKVILLE - 20050-12-2883

02

XX

Silver Spring

House 175

Silver Spring

Onto

Robert E. Johnson

Isaac W. Ellison

250-12-2883

Lorraine Morrison (Lawrence)

Isaac W. Ellison

Isaac W. Ellison

burial

2-2-00

all reported center

2000 in center, North, 15

240 Washington Street

Rockville, MD 20850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 0 0 2 1 0 3   |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irissa FAYE NICHOLSON</b>  |  |   |  | 2c. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 30 1980</b>   |  | 2b. HOUR<br><b>4:15A<sub>M</sub></b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 13 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Delaware</b>   |  | 13b. COUNTY<br><b>Sussex</b>  |  | 13c. CITY OR TOWN<br><b>Georgetown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>242 South Front Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Stewart</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Melvina Mullins</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>228-18-4623</b>  |  | 17. INFORMANT ADDRESS<br><b>Loran L. Nicholson See item 13</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Small cell lung cancer,</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I/ (this hospital) attended the deceased from <b>January 29</b> , 19 <b>80</b> , to <b>January 30</b> , 19 <b>80</b> , that (I/ (we) lost saw the deceased alive on <b>January 30</b> , 19 <b>80</b> , and that in (my/ (our) opinion death occurred on the date and hour and from the causes stated above, (I/ (we) did/ (did not) view the body after death.       |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jerome J. Roche Jr.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>Jan. 30, 1980</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerome J. Roche, Jr.</b>  |  |   |  | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-2-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Pleasant Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Kingston Ross Ohio</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robt. A. Pumphrey Funeral Home, Bethesda, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 0 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robt. A. Pumphrey</b>  |  |  |  |

BP



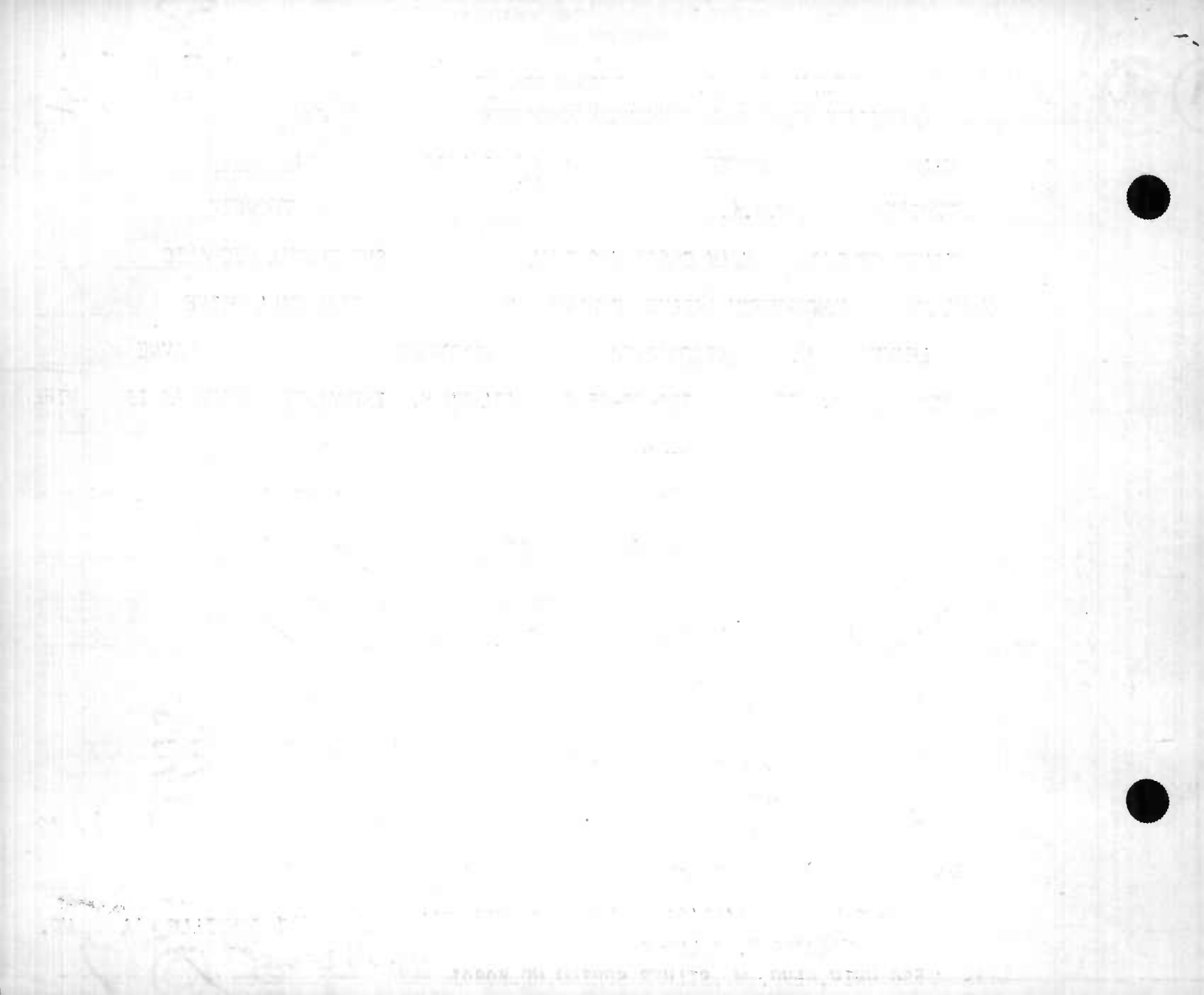


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

REG. NO. 02104

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 02104   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES A. NISEWARNER, SR.</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/8/80</b>   |  |   |  |
| 3. SEX <b>MALE</b>  |  |   |  | 7b. HOUR <b>10 45 AM</b>   |  |   |  |
| 4. RACE <b>WHITE</b>  |  |   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 31, 1918</b>  |  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.  |  |   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  |   |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHEETMETAL MECHANIC</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>                        |  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 13a. STREET ADDRESS <b>3202 PAUL DRIVE</b>   |  |   |  |
| 13b. COUNTY <b>MONTGOMERY</b>   |  |   |  | 13c. CITY OR TOWN <b>SILVER SPRING</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>LESTER H. NISEWARNER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERTRUDE PAYNE</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |  |   |  | 16b. SOCIAL SECURITY NO <b>578-09-0523</b>   |  |   |  |
| 17. INFORMANT <b>AILEEN M. NISEWARNER</b>   |  |   |  | ADDRESS <b>SAME AS 13 WIFE</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CAARD-RESPIRATORY ARREST</b><br>2396<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Symptoms increased intracranial pressure in month</b><br>(c) <b>massive BRAIN tumor</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>12/10/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN Tumor</b> |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 11</b> , 19 <b>79</b> , to <b>1-8</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>1-8</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Bernard Topak MD</b>  |  |   |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>1/9/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD TOPAK M.D.</b>   |  |   |  | 22e. ADDRESS <b>5454 LUTHERAN Ave. Ch. Ch. Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>1/11/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LAKEMONT MEMORIAL CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>DAVIDSONVILLE AA MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1980</b>   |  |   |  |
| 25b. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

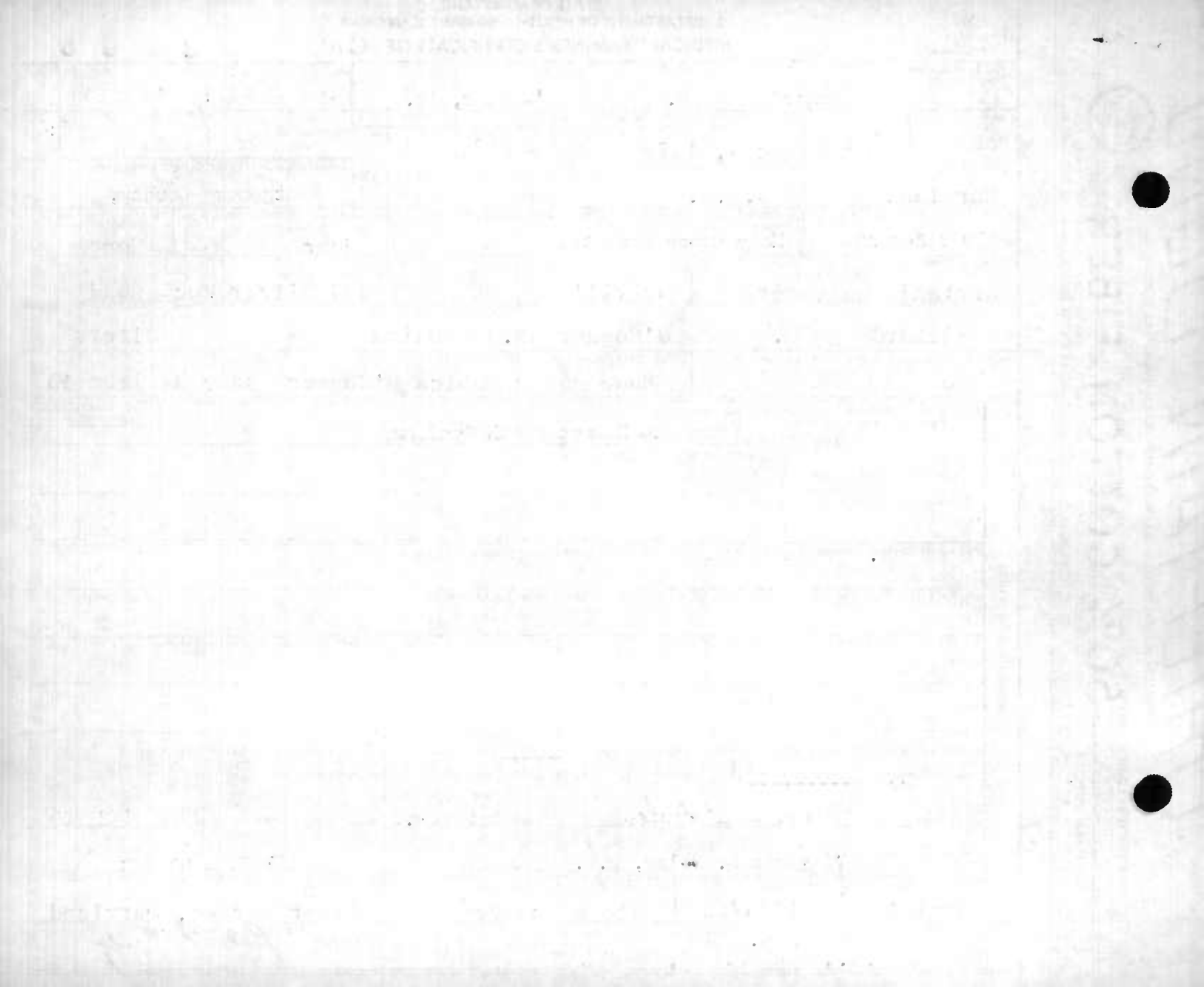
| FOR<br>1- STATE REGISTRAR   |  |                  |  |   |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |  |  | REG. NO. 02105 |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|----------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Flora Lemen Noll   |  |                  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1-1-80 |  |   |  |  |  | 2b. HOUR<br>A M   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 21 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD<br>Jan-1-80  |  | 2d. HOUR<br>1 P M   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8405 Dixon Ave. Apt. #4 |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Clerk  |  |  |  | 12b. KIND OF BUSINESS<br>MD. in Employment Office                                   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>8405 Dixon Ave. Apt. #4                   |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel Schnebly   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Curfman                 |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>-----  |  |                  |  |   |  | 16b. SOCIAL SECURITY NO.<br>214-09-9047   |  | 17. INFORMANT (daughter) Rt. 2 Box 238 S.<br>Margaret A. Atkinson Narcissis Rd.   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>1749 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Rt. Breast</u>  |  |                  |  |   |  |   |  |   |  |  |  |   |  | 18b. INFORMATION RELAYED TO THE MEDICAL EXAMINER IN WRITING |  |  |  |  |  |  |  |  |  |                |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| ACTUAL SIGNATURE<br>John G. Ball  |  |                  |  | TITLE (SPECIFY)<br>Deputy   |  |   |  | DATE SIGNED<br>Jan 1, 1980  |  |  |  | MEDICAL EXAMINER  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball, MD  |  |                  |  | ADDRESS<br>7936 Old Georgetown Rd. Beth.  |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>Jan. 4, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National                        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Virginia |  |   |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.,<br>8434 Ca. Ave., S.S. Md.  |  |                  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1980   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Henry M. Brady  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |

1. Name of Deceased: [illegible]  
2. Date of Death: [illegible]  
3. Place of Death: [illegible]  
4. Cause of Death: [illegible]  
5. Manner of Death: [illegible]  
6. Signature of Examiner: [illegible]  
7. Date of Report: [illegible]  
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202 JUL 1 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |   |   |                  |   |   | REG. NO. 02106  |  |
|--|------------------|---|--|---|---|---|------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Richard M. O'Connor, Jr.  |                  |   |  |   |   |   |                  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 20 19 80 |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 3, 1979   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 17 | IF UNDER 24 HRS.<br>HOURS MIN.<br>17  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 20 19 80        |   | 2d. HOUR<br>4:44 |   | 2e. AM  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD                                   |                  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                           |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None                             |   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |   |  |   |   |   |                  |   |   |   |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 13e. STREET ADDRESS<br>304 Silver Rock Road                           |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard M. O'Connor Sr.  |                  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Monica Walters |   |                  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMANT ADDRESS<br>Monica O'Connor same as item 13  |   |   |                  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |   |  |   |   |   |                  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |   |   |                  |   |   |   |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |   |   |   |                  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |  |   |   |   |                  |   |   |   |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan</u>   |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                |   |   | MEDICAL EXAMINER  |                  |   | DATE SIGNED<br>1/21/80  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |   | ADDRESS<br>111 Penn Street                                       |   |   |   |                  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  |   | 23b. DATE<br>1/23/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven            |   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. BUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND   |                  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1980  |                  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard A. Brady</u>                 |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 80 02107  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT E O'CONNOR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 9 80 |   |  | 2b. HOUR<br>10 <sup>15</sup> A.M.  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 21, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CITY MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BAKER                       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>SILVER SPRING  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>14000 CASTLE BOULEVARD  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MICHAEL O'CONNOR   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET SHEEHAN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-09-6779   |  | 17. INFORMANT<br>ADDRESS<br>CATHERINE M. O'CONNOR SAME AS 13 WIFE   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hrs |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>bronchopneumonia</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25 to 1/9/80, that (I/we) last saw the deceased alive on 1/9/80, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Myron L. Lenkin  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>1/10/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MYRON L. LENKIN   |  |  |  | 22e. ADDRESS<br>2389 SHOREFIELD RD WILKESBORO MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(STATE)<br>BURIAL   |  | 23b. DATE<br>1/12/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS<br>5000 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Rita M. Brady   |  |  |  |

BP \_\_\_\_\_





DHMH - 17  
(VR 115 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 2108

|   |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
|---|--|---------------|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------|--|
| 1. FOR STATE REGISTRAR  |  |               |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 5 19 80 |  |  |  |  |  |  |  |  |  | 2b. HOUR 12 PM |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE M. OHANESON  |  |               |  |   |  |   |  |  |  | 2c. DATE PRONOUNCED DEAD Jan. 5. 1980  |  |  |  |  |  |  |  |  |  | 2d. HOUR 12 PM |  |
| 3. SEX FEMALE   |  | 4. RACE WHITE |  | 5. DATE OF BIRTH MONTH DAY YEAR 07 04 94  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.                 |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.                              |  |  |  |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TURKEY  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH BETHESDA  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER          |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY HOME |  |  |  |                |  |
| 13a. STATE RHODE ISLAND   |  |               |  |   |  |   |  |  |  | 13b. CITY OR TOWN PROVIDENCE   |  |  |  | 13c. STREET ADDRESS 7 RUXTON STREET          |  |  |  |  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST RICHARD SERDJENIAN  |  |               |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MOUSAIAN                             |  |  |  |  |  |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO   |  |               |  | 16b. SOCIAL SECURITY NO. 004-48-6573  |  |   |  | 17. INFORMANT ADDRESS 5817 DURBIN ROAD, BETHESDA MD. EDWARD M. OHANESON, M.D.  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Cardio Vascular Disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |               |  |   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE John G. Ball   |  |               |  | TITLE (SPECIFY) M.D. DePoty   |  |   |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED Jan 5. 1980 MD   |  |  |  |  |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.  |  |               |  | ADDRESS 7936 Old Georgetown Rd., Bethesda   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               |  | 23b. DATE 1/9/80  |  | 23c. NAME OF CEMETERY OR CREMATORY Forest City Cemetery |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Portland, Maine                              |  |  |  |  |  |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey, P.R. 7557 Wisconsin Ave., Bethesda, MD   |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 25a. DATE REC'D. BY REGISTRAR 1010 1980   |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 25b. REGISTRAR'S SIGNATURE  |  |               |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |

NO. 100,000

STANDARD HOSPITAL

BETHESDA

CLINICAL

STATION

100,000

100,000

100,000

100,000

100,000

100,000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 02109

|   |  |   |   |   |                                   |   |                                      |                |  |
|---|--|---|---|---|-----------------------------------|---|--------------------------------------|----------------|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH                                     |   | 2b. DATE KNOWN OF ESTIMATED DEATH   |                                   | 2c. DATE PRONOUNCED DEAD  |                                      | 2d. HOUR       |  |
| DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |   | MIDDLE  |                                   | LAST  |                                      | MONTH DAY YEAR |  |
| Paul W Oliver   |  |   |   |   |                                   |   |                                      | 1 31 80 11 AM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.                  |   |                                      |                |  |
| Male  | Cauc.  | Oct. 8, 1921  | 58 YRS.   |   |                                   |   |                                      |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             |   | 8. MARRIED  |   | NEVER MARRIED                     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |                |  |
| Ohio  | U.S.A.   |   | WIDOWED   |   | DIVORCED                          |   | Montgomery                           |                | MD.  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |                                      |                |  |
| Bethesda  | Suburban Hospital  |   | Ret. U.S. Navy  |   | US Gov't.                         |   |                                      |                |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                                   |   |                                      |                |  |
| Maryland  | Montgomery   | Chevy Chase   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5031 Bradley Blvd. #1   |                                   |   |                                      |                |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                    |   |   |                                   |   |                                      |                |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |   |                                   |   |                                      |                |  |
| Claire Oliver   |  | Della Welch   |   |   |                                   |   |                                      |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                    |   | 17. INFORMANT   |                                   | ADDRESS   |                                      |                |  |
| Yes   |  | 1941-1956   |   | Trinidad R. Oliver,   |                                   | Same as #13   |                                      |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |                                   |   |                                      |                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY:   |  |   |   |   |                                   |   |                                      |                |  |
| IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>  |  |   |   |   |                                   |   |                                      |                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |                                   |   |                                      |                |  |
| (b) <u>Amiotrophic Lateral Sclerosis -</u>  |  |   |   |   |                                   |   |                                      |                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |                                   |   |                                      |                |  |
| (c)   |  |   |   |   |                                   |   |                                      |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |                                   |   |                                      |                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |                                   | 20. AUTOPSY?  |                                      |                |  |
|   |  |   |   |   |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |   |                                      |                |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                    |   |   |                                   |   |                                      |                |  |
|   |  | P.M. 19   |   |   |                                   |   |                                      |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION   |                                   | CITY OR TOWN  |                                      | COUNTY         | STATE  |
|   |  |   |   | STREET  |                                   |   |                                      |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |   |                                   |   |                                      |                |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |   | DATE SIGNED   |                                   |   |                                      |                |  |
| John G. Ball  |  | M.D. Deputy   |   | Jan 31, 1980  |                                   |   |                                      |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |   |   |                                   |   |                                      |                |  |
| John G. Ball, M.D.  |  | 7936 Old Georgetown Road                                    |   | Bethesda, Maryland  |                                   | 20014   |                                      |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                          |   | 23d. LOCATION   |                                   | CITY OR TOWN  |                                      | COUNTY         | STATE  |
| Burial  | 2/6/80   | Arlington Nat. Cem.   |   | Arlington, Virginia   |                                   |   |                                      |                |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                               |   | 25b. REGISTRAR'S SIGNATURE  |                                   |   |                                      |                |  |
| NAME  |  | FEB 13 1980   |   | M. J. McCreedy  |                                   |   |                                      |                |  |
| Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland   |  |   |   |   |                                   |   |                                      |                |  |

MEDICAL CERTIFICATION

2

BP

4802



05 12 50

Elmer

Paul

1941-1950

Montgomery

Referring

Referring

1941-1950

1941-1950

1941-1950

1941-1950

1941-1950

1941-1950



1941-1950

1941-1950

1941-1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 0002110   |  |   |  |  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR MIN                                      |  |
| ALEX   |  | F  |  | ONSON   |  |  |  | JAN. 7, 1980  |  | 1:15 P.M.   |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                       |  |
| MALE   |  | WHITE  |  | AUG. 24, 1895   |  | 84 YRS.  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| ESTONIA  |  | U.S.A.   |  |   |  | MONTGOMERY Co., MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| KENSINGTON   |  | KENSINGTON GARDELS NURSING HOME  |  |   |  |  |  | CARPENTER   |  | CONSTRUCTION                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| -  |  | -  |  | WASHINGTON, D.C.  |  |  |  | 229 PENNSYLVANIA AVE., S.E.   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |   |  |
| (- UNKNOWN -)  |  |  |  | (- UNKNOWN -)   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  | ADDRESS   |  |   |  |
| NO   |  |  |  | 579-05-2484   |  | ELEANOR KING   |  | 8514 POTOMAC AVENUE COLLEGE PARK, MARYLAND  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1889 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1978 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19 to 1/7/80, that (I) (we) lost saw the deceased alive on DEC. 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 27b. SIGNATURE   |  |  |  | DEGREE  |  |  |  | 27c. DATE SIGNED  |  |   |  |
|  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  |  | 1/7/80  |  |   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 27e. ADDRESS  |  |  |  |   |  |   |  |
| CSOTH  |  |  |  | LEKAGUL MD 7425 ARLINGTON RD BETHesda, MD   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| BURIAL   |  | JAN. 10, 1980  |  | CEDAR HILL CEMETERY   |  | SUITLAND-PRINCE GEO. Co. - MD.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                        |  |
| CHAMBERS FUNERAL HOME - RIVERDALE, MARYLAND  |  |  |  |   |  |  |  | JAN 16 1980   |  | P. J. H. H. H.                                    |  |

BP





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checked by *Med Examiner*

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR (AKA) <sup>(2)</sup> ANNIE LAURA OSBOURN  |  | REG. NO. 8002111   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>LAURA M. OSBOURN</u>   |  | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>2</u> YEAR <u>80</u>   |  | 7b. HOUR <u>9:30</u> A.M.   |  |   |  |  |  |
| 3. SEX <u>FEMALE</u>   |  | 4. RACE <u>CAUCASIAN</u>   |  | 5. DATE OF BIRTH MONTH <u>APRIL</u> DAY <u>5</u> YEAR <u>1887</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WASHINGTON, D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>ROCKVILLE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHADY GROVE ADVENTIST HOSPITAL</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOMEMAKER</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE <u>MARYLAND</u>   |  | 13b. COUNTY <u>MONTGOMERY</u>  |  | 13c. CITY OR TOWN <u>GAITHERSBURG</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <u>201 RUSSELL AVE.</u>  |  |
| 14. FATHER'S NAME FIRST <u>LEWIS</u> MIDDLE <u>J.</u> LAST <u>MATTHEWS</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>NANNIE</u> MIDDLE <u></u> LAST <u>WILLIAMSON</u>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>  |  | 16b. SOCIAL SECURITY NO. <u>577-26-3051</u>  |  | 17. INFORMANT ADDRESS <u>HELEN O. LYNCH 6809 STONEWOOD TERR., MD.</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>years</u><br><u>years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u></u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <u>11/180 OCT 19 75</u> to <u>1/2 80</u> that (I) (we) lost saw the deceased alive on <u>1/1/80</u> and that in (my) (our) opinion death occurred on the date and hour <u>1/2 80</u> from the causes stated above. (If we did not view the body after death, so state.)   |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>Thos G. Ward</u>   |  | DEGREE <u></u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22b. DATE SIGNED <u>1/2/80</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thos G. WARD</u>  |  | 22d. ADDRESS <u>6116 ROBINWOOD, Bethesda, Md.</u>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |  | 23b. DATE <u>1-4-80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEM.</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>WASHINGTON D.C.</u>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES P/A</u>  |  | ADDRESS <u>ROCKVILLE MD.</u>   |  | 25. DATE REC'D. BY REGISTRAR <u>JAN 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |  |  |

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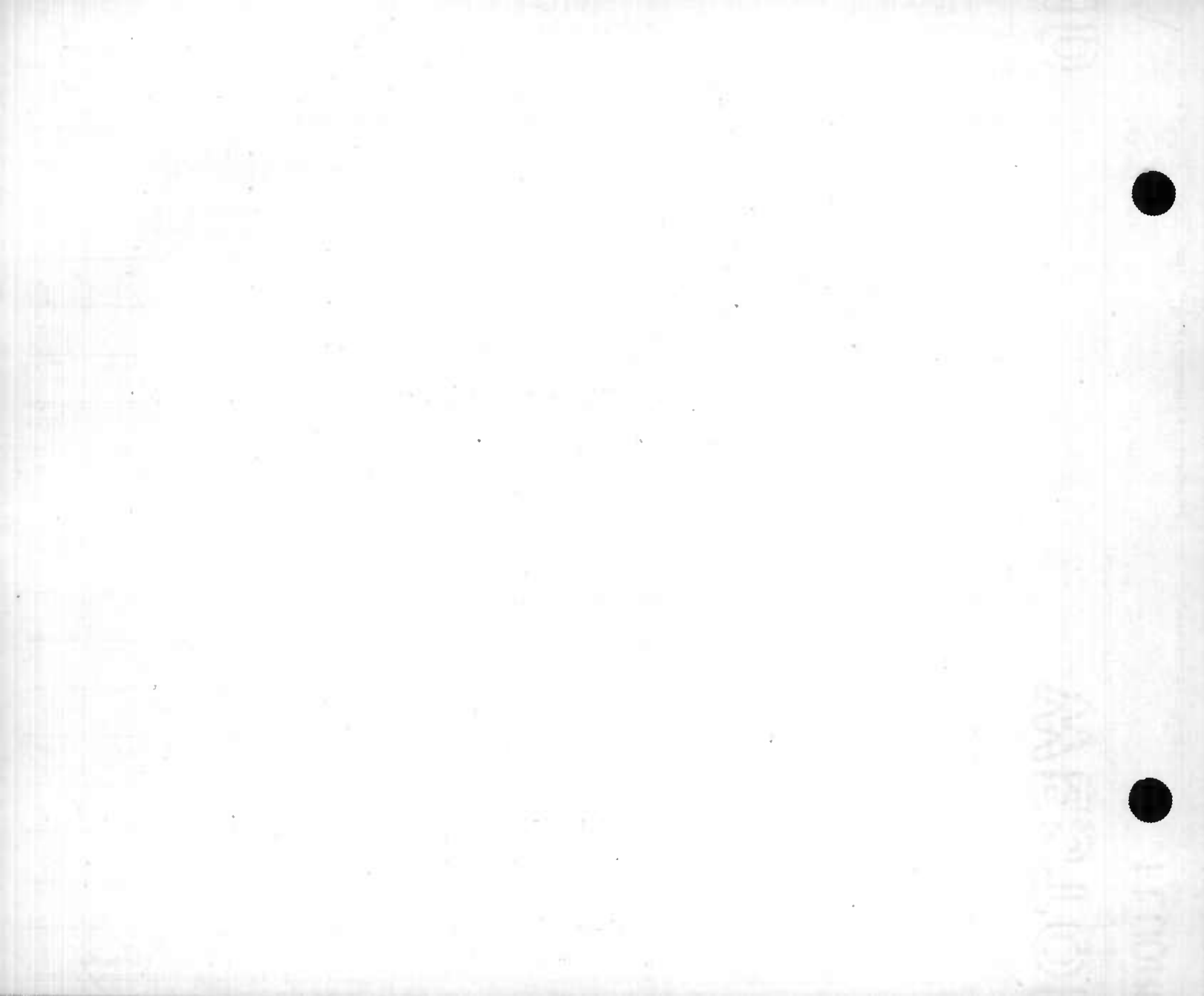
TO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |   |   |   |   | REG. NO. 8002112   |  |   |  |                              |  |
|--|--|--|--|--|---|---|---|---|---|--|--|---|--|------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |   |   |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b. HOUR                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ELMIRA H PARKER  |  |  |  |  |   |   |   |   |   | 1-31-80  |  |   |  | 8P M                         |  |
| 3. SEX female  |  |  | 4. RACE Negro  |  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 15 1910  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS                        |  | 8. IF UNDER 24 HRS HOURS MIN |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  |  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD  |  |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN PARAGRAPH 10, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private |                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>2nd 13b. CITY OR TOWN<br>Takoma Park   |  |  |  |  |   |   |   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6717 Poplar Ave                |  |                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Brockman   |  |  |  |  |   |   |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Estell Monroe                                  |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |  |   |   |   |   |   | 16b. SOCIAL SECURITY NO.<br>578 33 4448  |  | 17. INFORMANT ADDRESS<br>William Parker, husband, SAA |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 CARDIO-VASCULATORY failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) coronary insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF (c) MALNUTRITION, due to cancer.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 months |  |  |  |  |   |   |   |   |   |  |  |   |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>Carcinoma of left lung METASTASIS in Liver + bones   |  |  |  |  |   |   |   |   |   |  |  |   |  |                              |  |
| 19a. DATE OF OPERATION<br>NA   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NA   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |  |  |   |  |                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION STREET  |   | CITY OR TOWN  |   | COUNTY   |  | STATE   |  |                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1-9 1980 to 1-31 1980, that (I) (we) last saw the deceased alive on 1-31 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |   |   |   |   |   |  |  |   |  |                              |  |
| 22b. SIGNATURE<br>Veronica Troost MD.  |  |  |  |  |   |   |   |   |   | DEGREE   |  | 22c. DATE SIGNED<br>2.01.80                           |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VERONICA TROOST.  |  |  |  |  |   |   |   |   |   | 22e. ADDRESS<br>10236 N. HAMPSH. AVE. SS. MD 20903   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>6 Feb. 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Memorial Park |   |   | 23d. LOCATION CITY OR TOWN<br>Highland Park, P.G., Maryland |   | COUNTY STATE   |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>7400 Georgia Ave. NW, Wash. DC   |  |  |  |  |   |   |   |   |   | 25. DATE REC'D. BY REGISTRAR<br>FEB 11 1980  |  | 26. REGISTRAR'S SIGNATURE<br>History K. Brady         |  |                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8002113  |  | REG. NO.   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST<br>Alice   |  | MIDDLE<br>V.   |  | LAST<br>Payne   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
|  |  |  |  |  |  |   |  | 1-5-80  |  | 8:55 AM                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Female   |  | Cau  |  | Jan 26 88  |  | 91 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Virginia   |  | USA  |  |  |  | Montgomery MD   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| Silver Spring  |  | Carriage Hill Nursing Center   |  | Civil Service  |  | U.S. Govt.  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Maryland   |  | Montgomery   |  | Silver Spring  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 9101 2nd Avenue                              |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |
| John   |  | Alice A. Kearney   |  | 578-32-4667  |  | Niece-Catherine Keyes   |  | 207 Mayberry Ave. North Port Fla. 33596   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |  |  |
| No   |  | 578-32-4667  |  | Niece-Catherine Keyes  |  | North Port Fla. 33596   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Myocardial Infarction  |  |  |  |  |  |   |  |   |  | 1 day  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease   |  |  |  |  |  |   |  |   |  | 20 yrs.                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |  |  |  |
| Generalized Arteriosclerosis   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
|  |  |  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 73, to 5 January 19 80, that (we) lost saw the deceased alive on 5 January 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN  |  | MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| John F. Gustafson, M.D.  |  |  |  |  |  |   |  | 5 Jan. 80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |  |   |  |   |  |  |  |
| John F. Gustafson  |  | 5480 Wisconsin Ave, Chevy Chase, Md.   |  | JAN 10 1980  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| Burial   |  | 1/9/80   |  | Union Cemetery   |  | Leesburg  |  |   |  | Va.  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| Demaine Funeral Home   |  | Alexandria, Va. 22314  |  | JAN 10 1980  |  | [Signature]   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |                     |   |   |
|---|--|---|--|--|---|---|---------------------|---|---|
| 1- FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO. 80 02114  |  |   |   |                     |   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a DATE OF DEATH   |  |   | MONTH DAY YEAR  |                     | 2b HOUR   |   |
| NELLIE VIRGINIA PAYNE   |  |   | JANUARY 7, 1980  |  |   |   | 3:30 <sup>P</sup> M |   |   |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                     | 7 IF UNDER 1 YEAR   |   |
| FEMALE  |  | NEGRO   |  | APRIL 21, 1922   |   | 57 YRS  |                     | IF UNDER 24 HRS   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                     |   |   |
| Va.   |  | USA   |  |  |   | MONTGOMERY  |                     | MD  |   |
| 10 CITY OR TOWN OF DEATH  |  |   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |                     | 12b KIND OF BUSINESS OR INDUSTRY                                    |   |
| BETHESDA  |  |   | THE CLINICAL CENTER  |  |   | Unk   |                     | Unk   |   |
| 13a STATE   |  |   | 13b CITY OR TOWN   |  | 13c STREET ADDRESS                      |   | 20783               |   |   |
| MARYLAND  |  |   | HYATTSVILLE  |  | 630 SHERIDAN STREET, #30                |   |                     |   |   |
| 14 FATHER'S NAME  |  |   | 15 MOTHER'S MAIDEN NAME  |  |   |   |                     |   |   |
| Steven Payne  |  |   | Unk  |  |   |   |                     |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS                    |   |                     |   |   |
| No  |  |   | 229-12-9895  |  | MS. EVELYN BARBOUR, LYNCHBURG, VIRGINIA |   |                     |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |   |   |                     |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>   |  |   |  |  |   |   |                     |   |   |
| 1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |   |   |                     |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic breast ca. with pulmonary involvement</u>   |  |   |  |  |   |   |                     |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |   |   |                     |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |   |                     |   |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a AUTOPSY?  |                     | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |   |
|   |  |   |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                     |   |   |
|   |  | P.M. 19   |  |  |   |   |                     |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                     |   |   |
|   |  |   |  |  |   |   |                     |   |   |
| 22a I certify that (this hospital) attended the deceased from <u>December 19, 1979</u> to <u>January 7, 1980</u> , that (we) lost saw the deceased alive on <u>January 7, 1980</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) |  |   |  |  |   |   |                     |   |   |
| 22b SIGNATURE   |  |   |  | DEGREE   |   |   |                     | 22c DATE SIGNED   |   |
| <u>Byron H. Chesbro M.D.</u>  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |   |   |                     | 1/8/80  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e ADDRESS  |   |   |                     |   |   |
| BYRON H. CHESBRO, M.D.  |  |   |  | NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND   |   |   |                     |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |                     |   |   |
| Burial  |  | Jan 12, 80  |  | FOREST HILL  |   | Lynchburg, Virginia   |                     | 20205   |   |
| 24 FUNERAL DIRECTOR<br>NAME   |  | 24b FUNERAL HOME  |  | 25a DATE REC'D. BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE   |                     |   |   |
| JOHN T. RHINES  |  | 3015 12th St.<br>Washington, D.C.                                     |  | JAN 16 1980  |   | <u>Robert M. [Signature]</u>  |                     |   |   |



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COMMISSIONER OF THE  
BUREAU OF REVENUE

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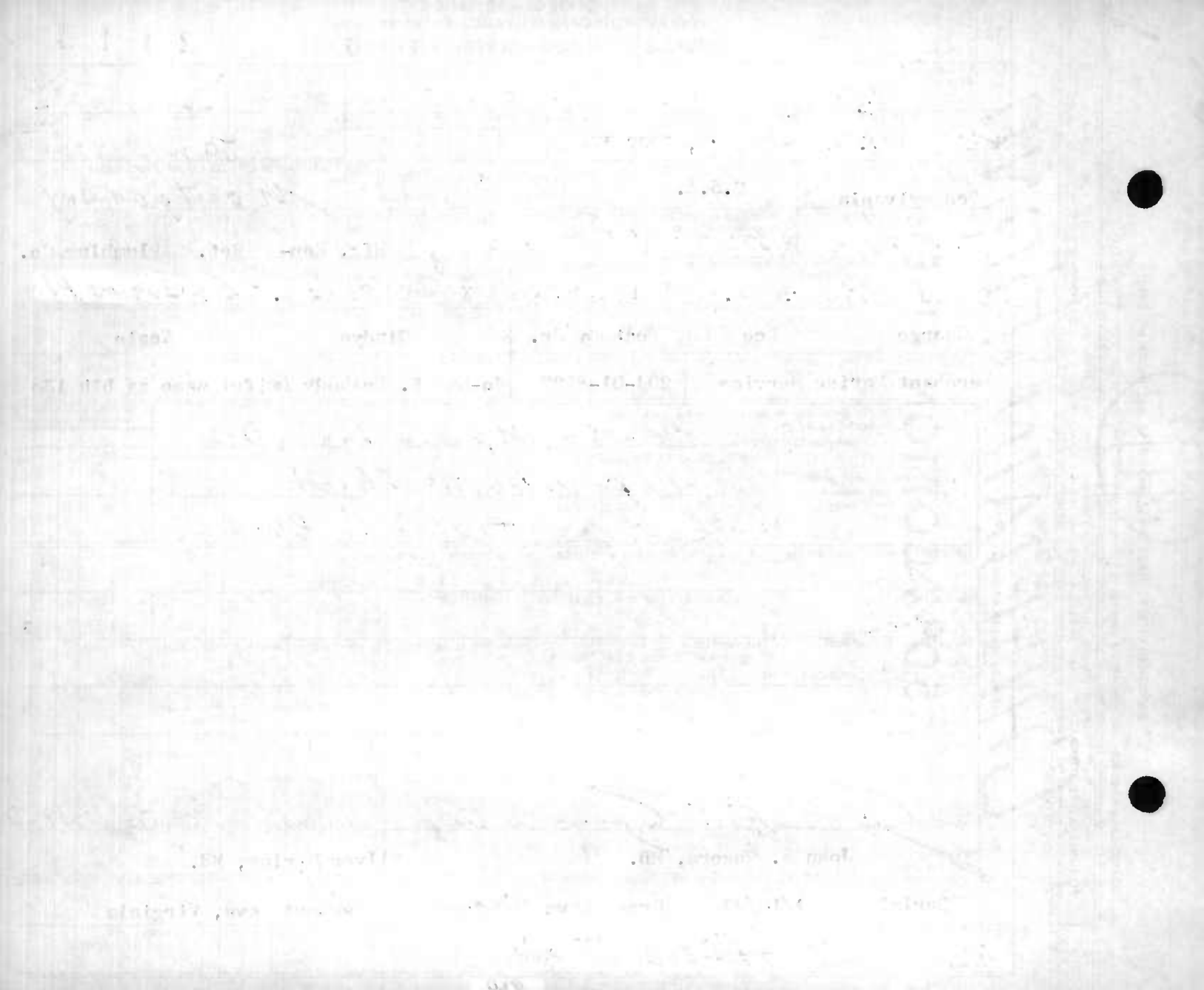
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3. YOUR SIGNATURE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |         |  |  |   |                   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                   |  |  |   |                                      |          |  |  | REG. NO. 02115 |  |
|--|--|---------|--|--|---|-------------------|--|---|--|--|--|-----------------------------------|--|--|---|--------------------------------------|----------|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |  | FIRST MIDDLE LAST   |                   |  |   |  | 2a. DATE KNOWN OF DEATH  |  |                                   |  |  | 2b. DATE ESTIMATED  |                                      |          |  |  | 2c. HOUR       |  |
| GEORGE LEE PEABODY III   |  |         |  |  |   |                   |  |   |  | Jan 13 1980  |  |                                   |  |  | Jan 13 1980   |                                      |          |  |  | 8:45 AM        |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD          |  |  |   |                                      | 7d. HOUR |  |  |                |  |
| MALE   |  | WHITE   |  | JUNE 22, 1922  |   | 57 YRS.           |  | MONTHS DAYS   |  | HOURS MIN.   |  | Jan 13 1980                       |  |  |   |                                      | 9 AM     |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                             |   |                   |  | 8. MARRIED  |  |  |  | NEVER MARRIED                     |  |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |          |  |  |                |  |
| Pennsylvania   |  |         |  | U.S.A.   |   |                   |  | WIDOWED   |  |  |  | DIVORCED                          |  |  |   | Montgomery MD.                       |          |  |  |                |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |   |                                      |          |  |  |                |  |
| TAKOMA PARK  |  |         |  | WASHINGTON ADVENTIST HOSPITAL                            |   |                   |  | Mfg. Rep- Ret.  |  |  |  | Plumbing Co.                      |  |  |   |                                      |          |  |  |                |  |
| 13a. STATE   |  |         |  | 13b. COUNTY  |   |                   |  | 13c. CITY OR TOWN   |  |  |  | 13d. INSIDE CITY LIMITS?          |  |  |   | 13e. STREET ADDRESS                  |          |  |  |                |  |
| MARYLAND   |  |         |  | PRINCE GEO.  |   |                   |  | COLLEGE PARK  |  |  |  | YES X NO                          |  |  |   | 9206 ST. ANDREW'S PLACE              |          |  |  |                |  |
| 14. FATHER'S NAME  |  |         |  |  | 15. MOTHER'S MAIDEN NAME                                    |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| George Lee Peabody Jr.   |  |         |  |  | Gladys Neale  |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  |  | 16b. SOCIAL SECURITY NO.                                    |                   |  |   |  | 17. INFORMANT  |  |                                   |  |  | ADDRESS   |                                      |          |  |  |                |  |
| Merchant Marine Service  |  |         |  |  | 204-01-8327   |                   |  |   |  | Jo-an K. Peabody (wife)  |  |                                   |  |  | same as blk 13e   |                                      |          |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                                      |          |  |  |                |  |
| PART 1 DEATH WAS CAUSED BY:  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u>  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| (b) <u>Hypovolemic Shock</u>   |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| (c) <u>Acute gastrointestinal Bleeding</u>   |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| <u>None</u>  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| 19a. DATE OF OPERATION   |  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  |   |  |  |  |                                   |  |  | 20. AUTOPSY?  |                                      |          |  |  |                |  |
| <u>None</u>  |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |          |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |  | 21b. TIME OF INJURY   |                   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |                                   |  |  |   |                                      |          |  |  |                |  |
|  |  |         |  |  | HOUR A.M. MONTH DAY YEAR                                    |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
|  |  |         |  |  | P.M. 19   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |  |   |  | 21f. LOCATION  |  |                                   |  |  |   |                                      |          |  |  |                |  |
|  |  |         |  |  |   |                   |  |   |  | CITY OR TOWN COUNTY STATE  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| ACTUAL SIGNATURE   |  |         |  |  | TITLE (SPECIFY)   |                   |  |   |  | MEDICAL EXAMINER   |  |                                   |  |  | DATE SIGNED   |                                      |          |  |  |                |  |
| <u>John S. Rogers</u>  |  |         |  |  | M.D. <u>Cap</u>   |                   |  |   |  |  |  |                                   |  |  | Jan 13 1980   |                                      |          |  |  |                |  |
| EXAMINER'S NAME  |  |         |  |  | ADDRESS   |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| John S. Rogers, MD.  |  |         |  |  | Silver Spring, Md.  |                   |  |   |  |  |  |                                   |  |  |   |                                      |          |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |  | 23b. DATE   |                   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                                   |  |  | 23d. LOCATION   |                                      |          |  |  |                |  |
| Burial   |  |         |  |  | 1/16/80   |                   |  |   |  | Green Lawn Cemetery  |  |                                   |  |  | Newport News, Virginia  |                                      |          |  |  |                |  |
| 24. FUNERAL DIRECTOR   |  |         |  |  | 25a. DATE REC'D. BY REGISTRAR                               |                   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |  |   |                                      |          |  |  |                |  |
| Francis Gasch's Sons, PA Hyattsville, Md.  |  |         |  |  | JAN 22 1980   |                   |  |   |  | <u>Montgomery</u>  |  |                                   |  |  |   |                                      |          |  |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 80 02116   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 26 80  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAE PERAU   |  |  |  | 2b. HOUR 7 <sup>10</sup> P.M.   |  |   |  |
| 3 SEX Female  |  | 4 RACE Caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1898  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |  |
| 10 CITY OR TOWN OF DEATH Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN Bethesda  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Moses --- Breakstone   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora --- Levinson   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |   |  |
| 16b. SOCIAL SECURITY NO N/A   |  | 17 INFORMANT ADDRESS Nancy Glick, 5112 Wickett Terr. Bethesda, Md.   |  | 17b. SOCIAL SECURITY NO 579-60-9830   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Cardiac arrest  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (if this hospital) attended the deceased from 19 78, to Jan 16, 19 80, that (I) (we) lost saw the deceased alive on Jan 15, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, did not view the body after death) |  |  |  |   |  |   |  |
| 22b. SIGNATURE Morton Shapiro, M.D.   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED 1-26-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton Shapiro, M.D.  |  | 22e. ADDRESS 5225 Pooks Hill Rd., Bethesda, Md.  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 1-29-80  |  | 23c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Washington, D. C.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM.  |  | ADDRESS CHAP. Rockville, Md.   |  | 25a. DATE RECEIVED BY REGISTRAR FEB 5 1980  |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Foght's may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |           |  |                   |  |         | REG. NO. 6002117                                  |         |                               |  |
|---|--|--|--|--|-----------|--|-------------------|--|---------|---|---------|-------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MARY   | MIDDLE H. | LAST PERRY   | 2a. DATE OF DEATH |  | MONTH 1 | DAY 14  | YEAR 80 | 2b. HOUR 2 <sup>00</sup> A.M. |  |
| 3 SEX Female  |  | 4 RACE White   |  | 5. DATE OF BIRTH   |           | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | 7. IF UNDER 1 YEAR   |         | 8. IF UNDER 24 HRS                                |         |                               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.   |  | 7b CITIZEN OF WHAT COUNTRY? USA.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |           | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep. (Ret)   |         | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store     |         |                               |  |
| 10 CITY OR TOWN OF DEATH SILVER SPRING  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE NURSING CONVA. CENTER |  | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |           | 12b. KIND OF BUSINESS OR INDUSTRY  |                   | 13a. STATE D.C.  |         | 13b. COUNTY Washington                            |         |                               |  |
| 14 FATHER'S NAME FIRST JOHN MIDDLE HAMILTON LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE HENRY LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |           | 16b. SOCIAL SECURITY NO. 578-12-5098   |                   | 17. INFORMANT ADDRESS  |         | 18. HOW DECEASED                                  |         |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure   |  | 19. DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia   |  | 20. DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Sclerosis  |           | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.   |                   | 22. 340 -  |         | 23. 3 days.                                       |         |                               |  |
| 24. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 25. DATE OF OPERATION  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED  |           | 27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                   | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |         | 29. 19  |         |                               |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |           | 33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                   | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |         | 35. LOCATION STREET CITY OR TOWN COUNTY STATE     |         |                               |  |
| 36. I certify that (I) (this hospital) attended the deceased from 1/15/80, 19, to 1/17/80, 19, that (I) (we) last saw the deceased alive on 1/17/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 37. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) S.A. Thomas MD  |  | 38. DEGREE   |           | 39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   | 40. DATE SIGNED 2/14/80  |         | 41. ADDRESS 4301 45th St N.W. Washington DC 20016 |         |                               |  |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 43. DATE 1/17/1980   |  | 44. NAME OF CEMETERY OR CREMATORY National Memorial Park Cem.  |           | 45. LOCATION CITY OR TOWN Falls Church, Va.  |                   | 46. COUNTY   |         | 47. STATE   |         |                               |  |
| 48. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.   |  | 49. ADDRESS 5130 Wisc. Ave. N.W.   |  | 50. DATE RECEIVED BY REGISTRAR 1/18/80   |           | 51. REGISTRAR'S SIGNATURE  |                   | 52. 1  |         | 53. 1   |         |                               |  |

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• I got a letter from him, too. • Two - 51-52

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO. 8002118   |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EMILY R. PERSON</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 4 80</b>  |   | 2b. HOUR<br><b>2:25 P M</b>  |   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MINNESOTA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>MONTGOMERY</b>  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>10807 FOLK STREET, SILVER SPRING</b>                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN ZBYTOVSKY</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY MARSH</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>508-24-7608</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>RUSSELL V. PERSON SAME AS 13 HUSBAND</b>        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY</b><br><b>1889</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CAROTID BLOOD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>THIR</b><br><b>9 YRS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/8</b> 19 <b>80</b> to <b>1/4</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>C. Seaton</b>  |   | DEGREE  |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDGAR H. LEVINE</b>   |   | 22e. ADDRESS<br><b>PC30 FEATENS L</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>1/8/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT. MD.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1980</b>  |   | 23f. REGISTRAR'S SIGNATURE<br><b>Anthony H. H. H.</b>                          |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |   | 24b. ADDRESS<br><b>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</b>   |   |  |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02119

1- FOR  
STATE  
REGISTRAR

|   |  |                  |  |  |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
|---|--|------------------|--|--|--|---|--|---|--|--|--|---|--|-----------|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Louise  |  | MIDDLE<br>(NMN)  |  | LAST<br>Pickering                             |  | 2a. DATE KNOWN<br>OF DEATH  |  | ESTI-<br>MATED <input checked="" type="checkbox"/> |  | MONTH<br>1  |  | DAY<br>23 |  | YEAR<br>80  |  | 2b. HOUR<br>M          |  |
| 3. SEX<br>female  |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 26, 1923  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>56 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE<br>PRONOUNCED<br>DEAD                     |  | MONTH<br>1  |  | DAY<br>24 |  | YEAR<br>80  |  | 2d. HOUR<br>11:03<br>M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Georgia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |           |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Springs   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11424 Stewart Lane, Apt C2 |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Waitress                    |  |           |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Irish Inn |  |                        |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Montgomery  |  |   |  | 13c. CITY OR TOWN<br>Silver Spring  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  | 13e. STREET ADDRESS<br>11424 Stewart Lane, Apt C2 |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Iola Huff   |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-20-8506   |  |   |  | 17. INFORMANT<br>2503 Bucklodge Rd<br>Gerald E. Pickering Adelphi, Md.  |  |  |  |   |  |           |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Incised wound of neck</u><br>966-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |  |                  |  |  |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |  |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |           |  |   |  |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10:30PM 1/23 1980   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>subject assaulted  |  |  |  |   |  |           |  |   |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>at home  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>11424 Stewart Lane, Apt C2, Silver Springs, MD Montgomery Co.  |  |  |  |   |  |           |  |   |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
| ACTUAL<br>SIGNATURE<br>Hormez R. Guard, MD.   |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | MEDICAL EXAMINER<br>111 Penn Street<br>Balto., MD 21201   |  |  |  | DATE<br>SIGNED<br>1/25/80   |  |           |  |   |  |                        |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                  |  | ADDRESS  |  |   |  |   |  |  |  |   |  |           |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1/28/80   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood P.G. Md.                                |  |           |  |   |  |                        |  |
| 24. FUNERAL DIRECTOR<br>Francis Gasch's Sons Funeral Home, P.A.<br>Hyattsville, Maryland  |  |                  |  |  |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1980  |  |           |  | 25b. REGISTRAR'S SIGNATURE<br>H. McCready         |  |                        |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  |                  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |                                 |  |  |                       |  |  |  | REG. NO. 02120       |  |
|--|--|------------------|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|-----------------------|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Carmen Joseph Pilla</i>   |  |                  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI. MATED <i>Jan 9, 1980</i>                             |  |  |                                 |  |  |                       |  |  |  | 2b. HOUR <i>8:00</i> |  |
| 3. SEX <i>M</i>  |  | 4. RACE <i>W</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>July 12 1921</i>   |  | AGE (IN YEARS LAST BIRTHDAY) <i>58</i>                   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <i>Jan 10, 1980</i>                                     |                                 |  |  | 2d. HOUR <i>11:00</i> |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, D. C.</i>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>                       |                                 |  |  |                       |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i>   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1110 Fidler Lane Apt 1213</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>COURT REPORTER</i>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                 |  |  |                       |  |  |  |                      |  |
| 13a. STATE <i>MD</i>   |  |                  |  | 13b. COUNTY <i>Mont</i>  |  | 13c. CITY OR TOWN <i>Silver Spring</i>                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <i>1110 Fidler Lane, Apt 1213</i>                              |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>ANTONIO PILLA</i>  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>CARMELLA DeGRASSO</i>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO. <i>577-03-1045</i>                                      |                                 | 17. INFORMANT <i>BROTHER JOSEPH J. PILLA</i> |  |                       |  |  |  |                      |  |
| 16c. ADDRESS <i>1601 OREBAUGH AVE. SILVER SPRING, MD.</i>  |  |                  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><i>4291</i> IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Chronic Myocardial Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Yrs.</i>   |  |                  |  |  |  |  |  |  |  |  |  |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                       |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 19a. DATE OF OPERATION <i>None</i>   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |  |                       |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i> M.D.  |  |                  |  |  |  |  |  |  |  | TITLE (SPECIFY) <i>Dep.</i> MEDICAL EXAMINER                                       |  |  | DATE SIGNED <i>Jan 10, 1980</i> |  |  |                       |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>  |  |                  |  |  |  |  |  |  |  | ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>                              |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  |  |                  |  | 23b. DATE <i>1/14/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i> |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>              |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>  |  |                  |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1980</i>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>   |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |
| 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901   |  |                  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |                       |  |  |  |                      |  |

17501 ORCHARD AVE  
STANLEY SPRING, MD.

JOSEPH J. TILLY  
527-63-1042  
TILLY

ANTONIO  
NO

CHURCH MEMBERS

WOMEN'S SOCIETY

1010 CLEVELAND ROAD STANLEY SPRING, MD.

JOHN S. ROGERS

STANLEY SPRING, MD.

DATE OF BIRTH

1911

1911

1911

1911

3301  
 Cleared by Dr. Rogers Mel E.  
 TO HOSPITAL'S ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 80 02121             |  |
|--|--|--|--|--|--|---|--|--|--|-------------------------------|--|
| 1- FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Joseph ALOYSIUS Pitts   |  | 2r. DATE OF DEATH MONTH DAY YEAR<br>11/7/80   |  | 7b. HOUR<br>2 30 PM  |  |                               |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>AUG 29, 1898   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |  |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL  |  | 12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ACCOUNTANT  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SO. RAILWAY CO.  |  |  |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>ROCKVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13r. STREET ADDRESS<br>5020 McCALL STREET  |  |                               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM H. PITTS   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>JULIA MALONEY   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>718-10-6311   |  | 17 INFORMANT<br>BIRDIE C. PITTS  |  | ADDRESS<br>SAME AS 13 WIFE    |  |
| MEDICAL CERTIFICATION  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial Infarct, & Cardiac arrest<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arterio Sclerotic Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>11/6/80<br>10 years |  |  |  |   |  |  |  |                               |  |
|  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |                               |  |
|  |  | 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                               |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21r PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from 11/30/63 19 to 11/7/80 19 that (I) (we) lost saw the deceased alive on 11/7/80 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |                               |  |
| 22b SIGNATURE<br>John J. Sweeney MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c DATE SIGNED<br>11/7/80   |  |   |  |  |  |                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>John J. Sweeney  |  | 22r ADDRESS<br>1905 Gatewood Place   |  |  |  |   |  |  |  |                               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>1/10/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.                             |  |  |  |                               |  |
| 24 FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS   |  | 24b ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 9 1980   |  | 25b REGISTRAR'S SIGNATURE<br>Ruthy McCreedy   |  |  |  |                               |  |





*[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | Phillip   |  | Phillip  |  | A.   |  | Racano   |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| 2b. DATE OF DEATH   |  | MONTH   |  | DAY  |  | YEAR   |  | 2c. HOUR   |  |
| 3. SEX  |  | male  |  | 4. RACE  |  | Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 95  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | Italy   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | Montgomery   |  | MD.  |  |
| 10. CITY OR TOWN OR DEATH   |  | Wheaton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | University of Md. Home   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | Building  |  | 13a. STATE   |  | MD   |  | 13b. COUNTY  |  |
| 13c. CITY OR TOWN   |  | Kensington  |  | 13d. INSIDE CITY LIMITS?   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | (unknown)   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | (unknown)  |  | 11915 Coronada Pl.   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | NO  |  | 16b. SOCIAL SECURITY NO  |  | 578-01-0119A   |  | 17. INFORMANT (daughter) ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA   |  | 5908  |  | DUE TO, OR AS A CONSEQUENCE OF (b) PYELONEPHRITIS  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE WEEK  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBROVASCULAR INSUFFICIENCY WITH SENILE INANITION |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 21g. I certify that (I) (this hospital) attended the deceased from 12/5/79 to 1/20/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. |  | 22a. SIGNATURE   |  | 22b. ADDRESS   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | MARTIN C. SHARGEL, M.D.   |  | 22e. ADDRESS   |  | 3720 FARRAGUT AVENUE KENSINGTON MD 20795   |  | 1/20/80  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | Burial  |  | 23b. DATE  |  | 1-23-80  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | Silver Spring Montgomery  |  | 23e. DATE RECEIVED BY REGISTRAR  |  | JAN 28 1980  |  | 23f. REGISTRAR'S SIGNATURE   |  |
| 24. FUNERAL DIRECTOR  |  | Warner E. Pumphrey, Inc.  |  | 24b. ADDRESS   |  | 8434 Ga. Ave., S.S. Md.  |  | 24c. SIGNATURE   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this form is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |  |  | REG. NO. 80 02123  |  |
|---|--|--|---|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 1a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>George H. Raub |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-21-80                                       |  |  | 2b. HOUR<br>3:15 PM                                      |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 16, 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |   | 7. IF UNDER 1 YEAR MONTHS DAYS                                   |  | 7. IF UNDER 24 HRS. HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                       |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   |  |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Miner                        |   |  | 12a. KIND OF BUSINESS OR INDUSTRY<br>Coal  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |  |   |  |  |  |  |
| 13a. STATE<br>Pa.   |  | 13b. COUNTY<br>Luzerne   |   | 13c. CITY OR TOWN<br>Newport Twn.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>#3 Kemar Terrace                          |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James A. Raub  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Deborah Thomas   |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>180-03-1978  |   | 17. INFORMANT ADDRESS<br>Dr. William Raub 11408 Rolling House Rd. Rockville, Md.   |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTIC MENINGITIS<br>5715<br>DUE TO, OR AS A CONSEQUENCE OF (b) CELLULITIS, LEG<br>3 DAYS<br>DUE TO, OR AS A CONSEQUENCE OF (c) HEPATIC CIRRHOSIS<br>YEARS                               |  |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 HOURS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |   |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 19 80 to JAN. 21 19 80, that (I) (we) lost saw the deceased alive on JAN. 21 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. |  |  |   |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Joseph D. Connor, MD  |  |  |   |  |  | DEGREE   |   | 22c. DATE SIGNED<br>JAN 22, 1980                                 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH D. CONNOR, MD   |  |  |   |  |  | 22e. ADDRESS<br>9420 OLD GEORGETOWN Rd. Bethesda, Md. 20014                                  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>1/25/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cemetery                         |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hanover Township, Pa. |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY<br>HOMES, P.A., BETHESDA, MARYLAND  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>H. J. McCreedy                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |   | 8 0 0 2 1 2 4<br>REG. NO.                    |   |  |  |
|---|--|--|--|---|---|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |  |  |   |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James E Ray  |  |  |  |   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 18, 1980                              |   |   | 2b. HOUR<br>4:15 A                           |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 2, 1925   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                       |   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center (NIH) |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                       |   |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Florida   |  |  |  |   |   |  | 13b. COUNTY<br>De Soto   |   | 13c. CITY OR TOWN<br>Arcadia  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William - Ray   |  |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace - Coker                       |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |   | 17. INFORMANT<br>Mrs. Ona Ray (wife)   |  |   | ADDRESS<br>(same as above)  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u><br>1729<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse, metastatic melanoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 30, 1979</u> to <u>Jan. 18, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan. 18, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |  |   |   |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Byron H. Chambers, M.D.</u>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>1/18/80   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Byron H. Chambers, M.D.  |  |  |  |   |   | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md, 20205  |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Jan/21/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Jonesville Cemetery                   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Oliver Springs, Tennessee |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chambers Funeral Home   |  |  |  |   |   | ADDRESS<br>Riverdale, Maryland   |  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

BP \_\_\_\_\_

THE UNIVERSITY OF CHICAGO  
LIBRARY

Chicago, Illinois  
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Dr. H. H. H. H.  
Chicago, Illinois

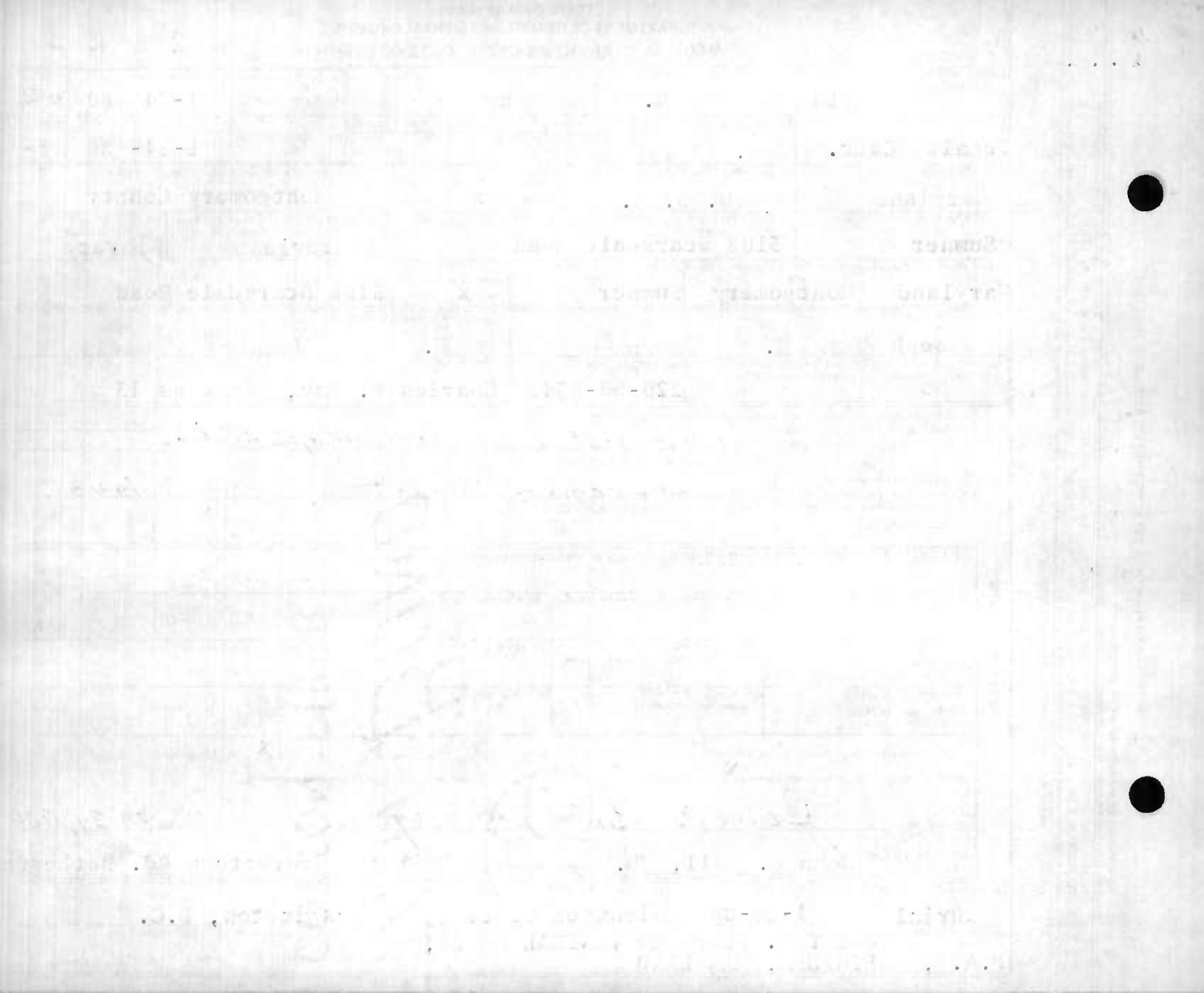
Chicago, Illinois  
The University of Chicago



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |   | REG. NO. 02125  |  |
|---|--|--|--|--|--|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lola B. Ray</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> 1-24-80 |   | 2b. HOUR<br>4:40 PM   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 19 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                 |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1-24-80</b>                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Library</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sumner</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5108 Scarsdale Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Librarian</b>               |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Library</b> |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Sumner</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5108 Scarsdale Road</b>                     |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph S. Bounds</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>E. Jennie Davis</b>  |  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>229-60-0345</b>   |  | 17. INFORMANT ADDRESS<br><b>Charles W. Ray, Same as 13</b>                                      |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of spine &amp; Pelvis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>1749</b><br>(b) <b>Carcinoma of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1963</b>                             |  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |  |  | TITLE (SPECIFY)<br>M.D. <b>Deputy</b>  |  |   |  | DATE SIGNED <b>Jan. 24, 1980</b>                                      |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, MD.</b>  |  |  |  | ADDRESS <b>7936 Old Georgetown Rd. Bethesda</b>  |  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-28-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT A. PIMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Litkey McCreedy</b>                  |   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. IF YOU ARE THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02126

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1- STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH                                       |   | 2b. HOUR  |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2c. DATE ESTIMATED  |   | 2d. HOUR  |   |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR  |   | MONTH DAY YEAR  |   |
| William F. Reed  |  | 1 21 19 80  |   | 9:04 PM   |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. DATE PRONOUNCED DEAD   | 8. MARRIED  |
| male   | white  | MONTH DAY YEAR  | LAST BIRTHDAY   | 1 21 19 80  | NEVER MARRIED   |
|  |  | 11 01 1916  | 63 YRS.   |   | WIDOWED   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                             | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |   |   |
| Washington D.C.  | U.S.A.   | Montgomery MD   |   |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |   |   |
| Silver Spring Md   | Holy Cross Hosp Silver Spring Md                         | Retired Chevrolet Inspector                                   |   |   |   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |
| Md   | Montg  | Silver Spg  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 10624 Eastwood Ave.   |   |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |   |   |   |
| FIRST MIDDLE LAST  | FIRST MIDDLE LAST  | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)             |   |   |   |
| Unknown  | Reed   | YES WWII  |   |   |   |
| 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | ADDRESS   |   |   |   |
| 578-07-7171  | Frances Reed (Wife)                                      | 13e.  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| IMMEDIATE CAUSE (a) Acute Myocardial Dis   |  |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |   |
| (b) Chronic Myocardial Dis   |  |   |   |   | Xrs   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |   |
| (c)  |  |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |   |
| None   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |   |   | 20. AUTOPSY?  |
| None   |  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
|  |  | P.M. 19   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |
|  |  |   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |   |   |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |   | DATE  |   |
| John P. O'Keefe  |  | M.D. Dep.   |   | Jan 22, 1980  |   |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |   |   |   |
|  |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   |
| Burial   |  | Jan 24, 1980  |   | Garden Hill   |   |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                                 |   | 25b. REGISTRAR'S SIGNATURE  |   |
| Name   |  | JAN 28 1980   |   | Henry McCready  |   |
| William Walters  |  | Washington D.C. 20002   |   |   |   |

158-10-312

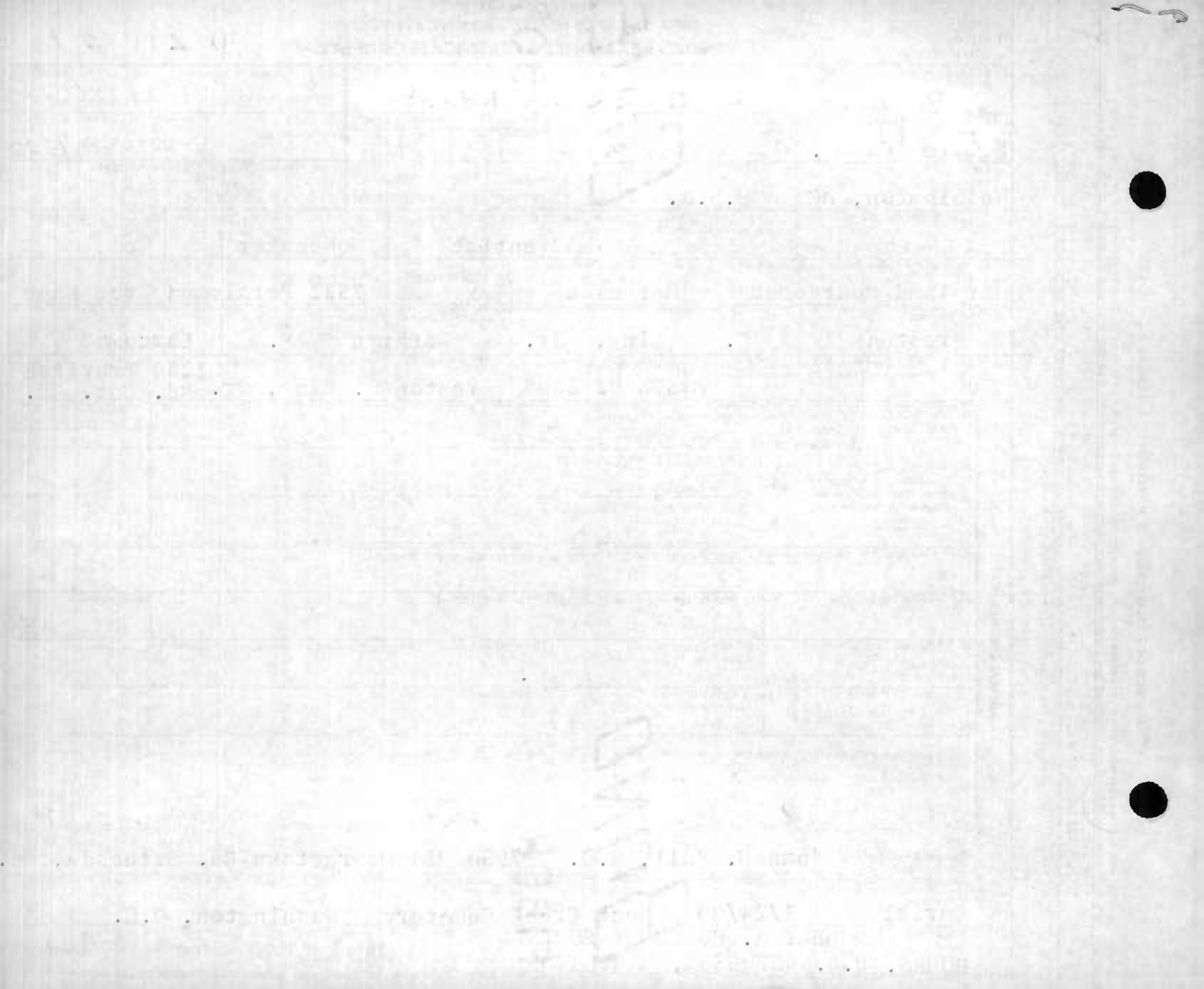
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24

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | REG. NO. 02127  |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR  |  | DECEASED NAME<br>FIRST MIDDLE LAST<br>BARBARA KING REICHELDERFER |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1-21 1980   |  | 2b. HOUR<br>1420 M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauca.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 27 34  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>45 YRS.                                 |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1-21 1980                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Bethesda   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>7522 Persimmon Tree Lane                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Preston C. King, Jr.  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathryn M. Larcumbe  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>578 92 2600   |  | 17. INFORMANT ADDRESS<br>Preston C. King, Jr. Rd. Pot. Md. 1260 Travilah      |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.<br>(b) <u>Hepatic Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF -<br>(c) <u>Chronic Alcoholism</u>   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>John G. Ball  |  |  |  | TITLE (SPECIFY)<br>Deputy   |  |   |  | DATE SIGNED<br>Jan 21, 1980   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball, M.D.  |  |  |  | ADDRESS<br>7936 Old Georgetown Rd. Bethesda, Md.  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>1/24/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rock Creek Cemetery                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Pietro McCready   |  |   |  |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |                          |  | REG. NO. 8002128                             |  |
|---|--|--|--|--|--|--|--|--------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                          |  | 2b. HOUR                                     |  |
|   |  | SAMUEL L. REINBOLD   |  |  |  | 1/6/80   |  |                          |  | 9:45 P.M.                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS; NEXT BIRTHDAY)   |  |                          |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| MALE  |  | WHITE  |  | 7 21 96  |  | 83 YRS.  |  |                          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                          |  |  |  |
| Penn.   |  | USA  |  |  |  | MONTGOMERY MD.   |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |  |  |
| Bethesda  |  | SUBURBAN HOSPITAL  |  | Bus & Forrest Ser.   |  | D.C.T.&Gov't   |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS      |  |  |  |
| Md.   |  | Montgomery   |  | Rockville  |  |  |  | 12000 Old Georgetown Rd. |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |                          |  |  |  |
| John P. Reinbold  |  | Virgil Felty   |  |  |  |  |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |                          |  |  |  |
| No  |  | 579-26-9085 A  |  | Ida Mae Reinbold Same as Item # 13   |  |  |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4414 Chronic renal failure  |  |  |  |  |  |  |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |  |  |                          |  | 10 days                                      |  |
| DUE TO OR AS A CONSEQUENCE OF (b) Dissection of abdominal aortic aneurysm   |  |  |  |  |  |  |  |                          |  |  |  |
| DUE TO OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                          |  |  |  |
| Dec 21 79   |  | abdominal aortic aneurysm  |  |  |  |  |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |                          |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY                   |  | STATE  |  |
|   |  |  |  |  |  |  |  |                          |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 22 19 80, to Jan 6 19 80, that (I) (we) lost saw the deceased alive on Jan 6 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                          |  |  |  |
| 22a. SIGNATURE  |  | DEGREE   |  | 22b. DATE SIGNED   |  |  |  |                          |  |  |  |
| Joseph F. Schanno   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | Jan 7, 80  |  |  |  |                          |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22d. ADDRESS   |  |  |  |  |  |                          |  |  |  |
| Joseph F. Schanno, MD   |  | 2218 Wisconsin Ave NW  |  | Bethesda, Md.  |  |  |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |  | COUNTY                   |  | STATE  |  |
| Burial  |  | Jan. 9, 1980   |  | Ft. Lincoln Cemetery   |  | Brentwood, Md.   |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |  |  |
| Joseph Gawler's Sons, Inc.  |  | 5130 Wisc. Ave. N.W. Wash., D.C.   |  | JAN 11 1980  |  | L. H. McCreedy   |  |                          |  |  |  |





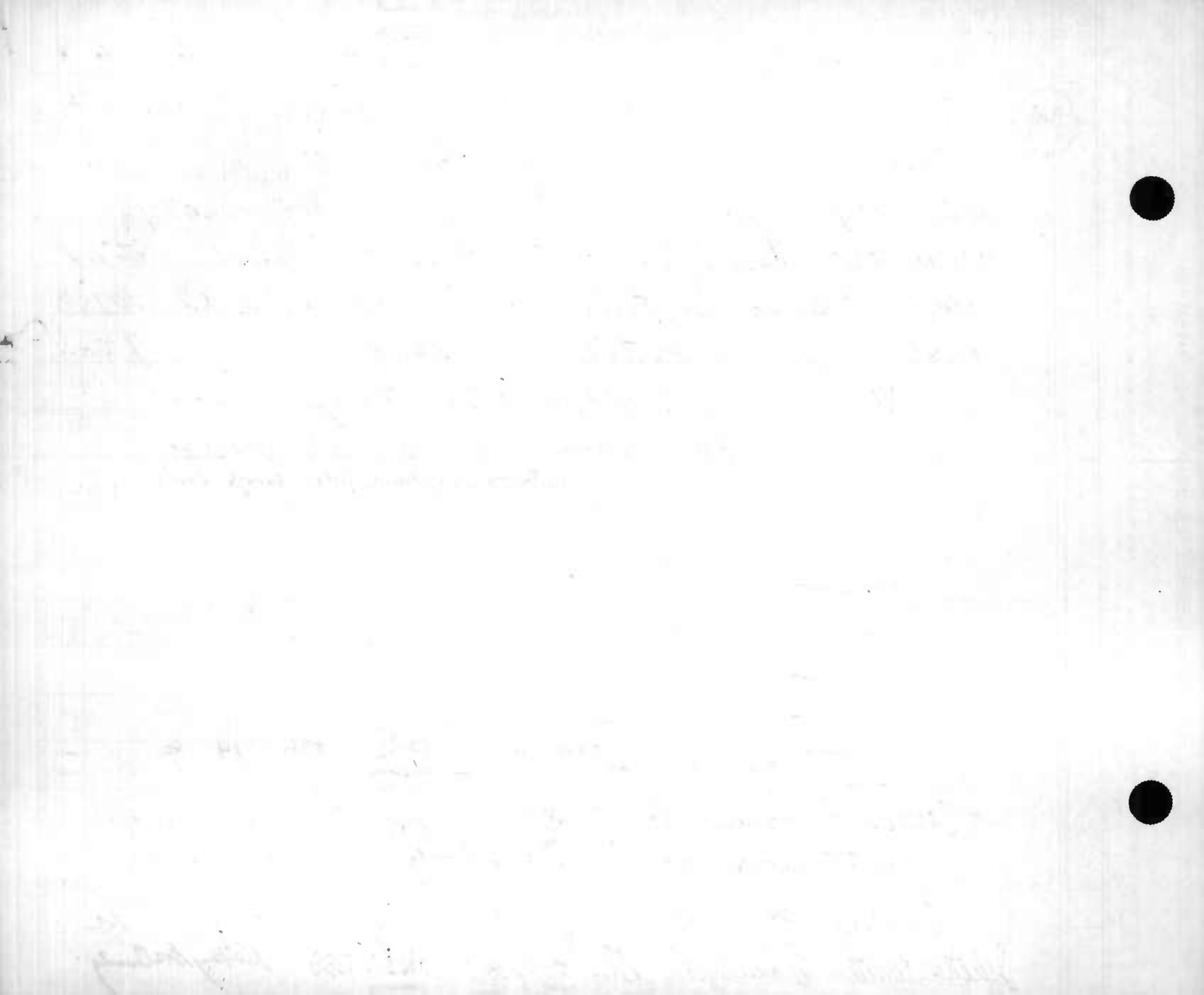
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8002129   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><u>Dorothy MAE REINTZE</u>  |  |   |  | 2b. HOUR<br><u>2:51 PM</u>   |  |   |  |
| 3 SEX<br><u>FEMALE</u>   |  | 4 RACE<br><u>WHITE</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>4-3-1931</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>48</u> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Montgomery</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Lanham Park</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Washington Adventist Hosp.</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Exec. Asst.</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY<br><u>1100 E. Co. Hyattsville</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><u>1603-Deyton Rd. 20783</u>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Robert J.</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Gene Beall</u>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>517-38-4912</u>  |  | 17. INFORMANT ADDRESS<br><u>Elton H. Reintze (13c)</u>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma, desc. colon, with generalized metastases (brain, liver, lungs, bone)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br><u>1532</u><br><u>1 yr.</u> |  |   |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>—</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>NA</u>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>— P.M. — 19 —</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>—</u>   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <u>NA</u>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>—</u>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><u>— — — — —</u>   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 11</u> 19 <u>79</u> to <u>Jan 14</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>Jan 14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>William F. Simpson, MD</u>  |  |   |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>1/14/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>William F. Simpson MD</u>  |  |   |  | 22e. ADDRESS<br><u>8106 N.H. Ave Silver Spring Md 20903</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>Jan. 17, 1980</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lakewood Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Luxay Va.</u>   |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Arthur Walters</u>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><u>JAN 17 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>History Healy</u>  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |                     |   |  |  |   |   |  |   |   |   |                            | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  | REC. NO. 02130 |  |
|--|---------------------|---|--|--|---|---|--|---|---|---|----------------------------|--|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elmer Alexander Reno</b>   |                     |   |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>Jan 23 1980</b>     |  |   |   | 2b. HOUR<br><b>12:25 AM</b>   |                            |  |  |  |  |                |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 21 78</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>78</b> YRS.                 | IF UNDER 1 YR.<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.                               |   | 2c. DATE PRONOUNCED DEAD<br><b>01 23 80</b>         |   | 2d. HOUR<br><b>1:25 AM</b> |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD |   |   |   |                            |  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery Gen. Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer Ret.</b>           |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Govt</b> |   |                            |  |  |  |  |                |  |
| 13a. STATE<br><b>MD</b>  |                     | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Sp. Sp.</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>56 Bonita 2nd Rd.</b>                               |   |   |                            |  |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Reno</b>   |                     |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Vasek</b>                           |  |   |   |   |                            |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>None</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>349 03 9629</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Jeanne H. Reno (Wife) Same as above</b> |   |   |  |   |   |   |                            |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>410- Acute Myocardial Dis.</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>Chronic Myocardial Dis.</b><br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                     |   |  |  |   |   |  |   |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Krs</b>                         |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                     |   |  |  |   |   |  |   |   |   |                            |  |  |  |  |                |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                     |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |                            |  |  |  |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                     |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |                            |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |   |  |  |   |   |  |   |   |   |                            |  |  |  |  |                |  |
| ACTUAL SIGNATURE<br><b>John Rogers</b>   |                     |   |  | TITLE (SPECIFY)<br><b>M.D.</b>   |   |   |  | DATE SIGNED<br><b>Jan 23 1980</b>   |   |   |                            | MEDICAL EXAMINER<br><b>1919 Seminary Rd. S.S.Md.</b>                               |  |  |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John Rogers</b>   |                     |   |  | ADDRESS<br><b>1919 Seminary Rd. S.S.Md.</b>                            |   |   |  |   |   |   |                            |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                     |   |  | 23b. DATE<br><b>1/26/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                               |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG Md</b>                |                            |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi F.H.</b>  |                     |   |  |  |   | ADDRESS<br><b>11800 N.H. Ave. S.S.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreary</b>                               |                            |  |  |  |  |                |  |

10:1 03. 51 10

10:1 03. 51 10

10

10:1 03. 51 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

| 1 - STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO. 8002131  |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Sarah Marie Rice</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 29 80</b>  |  | 2b. HOUR<br><b>8:14 AM</b>  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 21 1880</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>99 YRS.</b>           |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Mont.</b>  | 13c. CITY OR TOWN<br><b>Bethesda</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5820 Tanglewood Drive</b>                               |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jacob Benson</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie Peterson</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT ADDRESS<br><b>John R. Benson, Nephew. Same as item 13.</b>          |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>lung abscess</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Right upper lobe Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic heart disease - Pac &amp; PVC's</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 14, 1977</b> to <b>1/29</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/28</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Elba J. Martinez</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/29/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elba J. Martinez M.D.</b>   |  | 22e. ADDRESS<br><b>8808 Hidden Hill Lane Potomac, Md.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1/30/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>                |   |
| 23d. LOCATION CITY OR TOWN<br><b>Brentwood, Md.</b>   |  | COUNTY<br><b>Montgomery</b>   |  | STATE<br><b>Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc.</b><br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>                               |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>                               |   |

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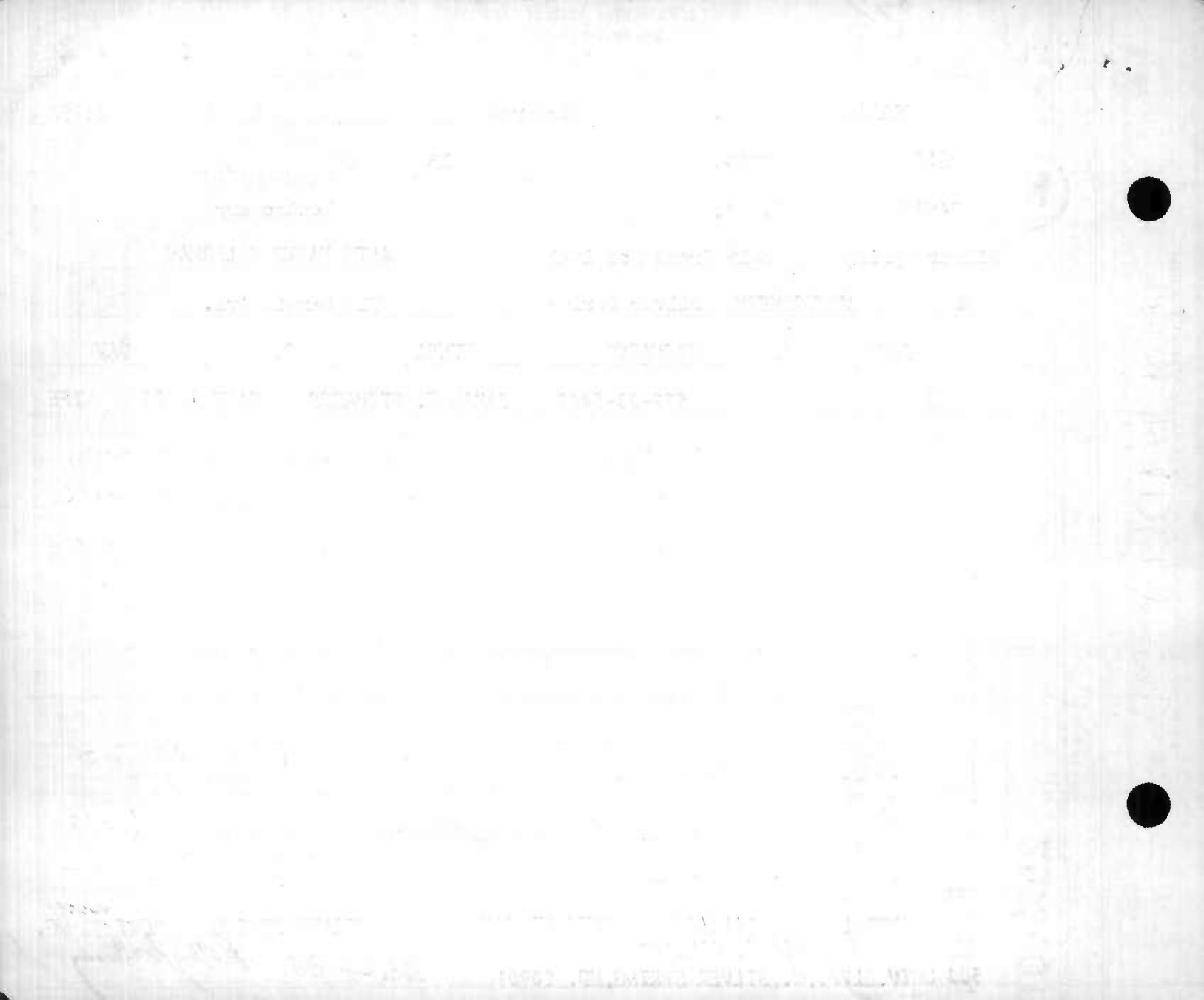


## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |                                   |  |
|---|--|--|--|--|--|--|--|-----------------------------------|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO. 80002132  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                          |  |
| FIRST   |  | MIDDLE   |  | LAST   |  | MONTH  |  | DAY                               |  |
| William   |  | A.   |  | Richards   |  | 1  |  | 10                                |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR                |  |
| MALE  |  | white  |  | MONTH DAY YEAR   |  | 66   |  | MONTHS DAYS                       |  |
| 2   |  | 8  |  | 13   |  | YRS  |  | HOURS MIN                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  | 10. MD.                           |  |
| CANADA  |  | U.S.A.   |  |  |  | Montgomery   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                   |  |
| Silver Spring   |  | Holy Cross Hospital  |  | AUTO PARTS SALESMAN  |  |  |  |                                   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS               |  |
| MD  |  | MONTGOMERY   |  | Silver Spring  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 718 Dennis Ave.                   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT ADDRESS             |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | NO   |  | 577-03-5488  |  | SARAH F. RICHARDS SAME AS 13 WIFE |  |
| JOHN  |  | O. RICHARDS  |  |  |  |  |  | DAY                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 496-   |  | one hour                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  | (b) <u>Severe hypoxemia</u>  |  | 2 months   |  |  |  |                                   |  |
|   |  | (c) <u>Chronic obstructive lung disease</u>  |  | 20 years   |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |                                   |  |
|   |  | P.M. 19  |  |  |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY STATE                      |  |
|   |  |  |  |  |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 30</u> , 19 <u>73</u> , to <u>1/10</u> , 19 <u>80</u> , that (I) (we) lost <u>see the deceased alive on Jan 1 19 80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |                                   |  |
| <u>Martin C. Shargel</u>  |  | M.D.   |  | 1/10/80  |  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE                                     |  |                                   |  |
| MARTIN C. SHARGEL   |  | 3720 FARRAGUT AVE KENSINGTON, MD - 20795   |  | JAN 16 1980  |  | <u>Anthony McCreedy</u>  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN                                     |  | COUNTY STATE                      |  |
| BURIAL  |  | 1/12/80  |  | GATE OF HEAVEN   |  | SILVER SPRING  |  | MONT MG.                          |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. DATE  |  | 24c. NAME OF CEMETERY OR CREMATORY   |  | 24d. LOCATION CITY OR TOWN                                     |  | COUNTY STATE                      |  |
| FRANCIS J. COLLINS  |  |  |  |  |  |  |  |                                   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |  |  |  |  |                                   |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |   |                  |  |  |  |                |   |                  |  |
|---|--|---------|---|------------------|--|--|--|----------------|---|------------------|--|
| REG. NO. 0 2 1 3 3  |  |         |   |                  |  |  |  |                |   |                  |  |
| FOR<br>1- STATE REGISTRAR   |  |         |   |                  |  |  |  |                |   |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST   |                  |  | 2a. DATE KNOWN OF DEATH  |  |                | 2b. HOUR  |                  |  |
| John Rice Rippey  |  |         |   |                  |  | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR   |  |                | 1/14 1980   |                  |  |
| 3. SEX  |  | 4. RACE |   | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR. |   | IF UNDER 24 HRS. |  |
| Male  |  | White   |   | Apr. 30, 1928    |  | 51 YRS.  |  | MONTHS DAYS    |   | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |  |
| Virginia  |  |         | USA   |                  |  |  |  |                | Montgomery County MD.   |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                | 12b. KIND OF BUSINESS, COMMUNICATIONS                               |                  |  |
| Silver Spring   |  |         | In front of 1200 Woodside Parkway   |                  |  | Salesman   |  |                | Communications  |                  |  |
| 13a. STATE  |  |         | 13b. COUNTY   |                  |  | 13c. CITY OR TOWN  |  |                | 13d. INSIDE CITY LIMITS?  |                  |  |
| Maryland  |  |         | Montgomery  |                  |  | Silver Spring  |  |                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME  |                  |  | 13e. STREET ADDRESS  |  |                |   |                  |  |
| Will Neeley   |  |         | Mildred Flanagan  |                  |  | 1017 Woodside Parkway  |  |                |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |         | 16b. SOCIAL SECURITY NO.  |                  |  | 17. INFORMANT (NAME AND ADDRESS)   |  |                |   |                  |  |
| yes   |  |         | WW11  |                  |  | Rita J. Rippey- (same as 13e)  |  |                |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |   |                  |  |  |  |                |   |                  |  |
| PART I DEATH WAS CAUSED BY:   |  |         |   |                  |  |  |  |                |   |                  |  |
| IMMEDIATE CAUSE (a) <u>Gunshot wound of head (shotgun).</u>   |  |         |   |                  |  |  |  |                |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |   |                  |  |  |  |                |   |                  |  |
| (b) _____   |  |         |   |                  |  |  |  |                |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |   |                  |  |  |  |                |   |                  |  |
| (c) _____   |  |         |   |                  |  |  |  |                |   |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |   |                  |  |  |  |                |   |                  |  |
| None  |  |         |   |                  |  |  |  |                |   |                  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |  |  |  |                | 20. AUTOPSY?  |                  |  |
| None  |  |         |   |                  |  |  |  |                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         | 21b. TIME OF INJURY   |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                |   |                  |  |
|   |  |         | 9:30 AM 1/14 1980   |                  |  | Shot self.   |  |                |   |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  |  | 21f. LOCATION  |  |                |   |                  |  |
|   |  |         | Street  |                  |  | Woodside Parkway, Silver Spring, Mont., Md.  |  |                |   |                  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |         |   |                  |  |  |  |                |   |                  |  |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  |         |   |                  |  |  |  |                |   |                  |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |   |                  |  |  |  |                |   |                  |  |
| ACTUAL SIGNATURE  |  |         | TITLE (SPECIFY)   |                  |  | DATE SIGNED  |  |                |   |                  |  |
| <i>John S. Rogers</i>   |  |         | M.D. Deputy   |                  |  | 1/14/80  |  |                |   |                  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         | ADDRESS   |                  |  |  |  |                |   |                  |  |
| John S. Rogers, M.D.  |  |         | 1919 Seminary Road  |                  |  | Silver Spring, Montgomery, Md.   |  |                |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE   |                  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                | 23d. LOCATION   |                  |  |
| Removal   |  |         | 1-14-80   |                  |  | George Washington Medical School   |  |                | Washington, DC  |                  |  |
| 24. FUNERAL DIRECTOR  |  |         | 25a. DATE REC'D. BY REGISTRAR   |                  |  | 25b. REGISTRAR'S SIGNATURE   |  |                |   |                  |  |
| Warner E. Pumphrey, Inc.  |  |         | JAN 18 1980   |                  |  | <i>John S. Rogers</i>  |  |                |   |                  |  |
| 8434 Ca. Ave., S.S. Md.   |  |         |   |                  |  |  |  |                |   |                  |  |

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area. This information is being provided to you for your information only and is not to be distributed outside of your organization.

2. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

6. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

7. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

8. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

9. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

10. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  | 8 0 0 2 1 3 4<br>REG. NO.  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |
|  |  |  |  |  | ALMA J. RITTER  |  |  |  |  | 1/12/1980  |  |  |  |  | 12 20 PM   |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE   |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |  |  |  |
| FEMALE   |  |  |  |  | WHITE   |  |  |  |  | FEB. 8, 1882   |  |  |  |  | 97 YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |  |
| VIRGINIA   |  |  |  |  | U.S.A.  |  |  |  |  |  |  |  |  |  | MONTGOMERY MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |  |
| TAKOMA PARK  |  |  |  |  | WASHINGTON ADVENTIST HOSPITAL   |  |  |  |  | HOUSEWIFE  |  |  |  |  | OWN HOME   |  |  |  |  |
| 13a. STATE   |  |  |  |  | 13b. COUNTY   |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |  | 13e. STREET ADDRESS  |  |  |  |  |
| MARYLAND   |  |  |  |  | PRINCE GEO. CHERVERLY   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 5411 MACBETH STREET  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| UNKNOWN  |  |  |  |  | VICKERS   |  |  |  |  | UNKNOWN  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  | 17. INFORMANT  |  |  |  |  | ADDRESS  |  |  |  |  |
| NO   |  |  |  |  | 224. 72 2095  |  |  |  |  | JoAnn Crawford   |  |  |  |  | Same as #13  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal gram negative Septicemia</i>   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |
| 0384   |  |  |  |  |   |  |  |  |  | 1/10/80  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |   |  |  |  |  | STREET   |  |  |  |  | CITY OR TOWN COUNTY STATE                                      |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978 to 1/12/80, that (I) (we) last saw the deceased alive on 1/11/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |  | 1/12/80  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OSOTH LEXAGU   |  |  |  |  | 7485 arlington Rd Bethesda Md   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION  |  |  |  |  |
| Burial   |  |  |  |  | 1/15/80   |  |  |  |  | Stonewall Mem. Gardens   |  |  |  |  | Manassas Prince Wm. Va.  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |  |
| Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland  |  |  |  |  |   |  |  |  |  | JAN 16 1980  |  |  |  |  | Ruthy Belamy   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 8002135<br>REG. NO.   |  |  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br><b>ALFRED</b>                      |  |   |  | MIDDLE<br><b>ROBERTS</b>   |  |   |  | LAST<br><b>ROBERTS</b>  |  |  |  | 2a. DATE OF DEATH<br><b>1/24/80</b>  |  | MONTH<br><b>10</b>   |  | DAY<br><b>10</b>  |  | YEAR<br><b>A</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>CAUCASIAN</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>14</b> DAY <b>1898</b> YEAR |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>                    |  | 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUILDING CONT</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b> |  |
| 13a. STATE<br><b>RHODE ISL.</b>  |  | 13b. COUNTY<br><b>KENT</b>   |  | 13c. CITY OR TOWN<br><b>WARWICK</b>                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>65 EDGEHILL ROAD</b>  |  | 14 FATHER'S NAME<br>FIRST <b>BENJAMIN</b> MIDDLE <b>ROBERTS</b> LAST <b>ROBERTS</b> |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>ELLEN</b> MIDDLE <b>WOLSTENHOLME</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  | 16b. SOCIAL SECURITY NO.<br><b>136 30 7461</b>                                 |  | 17 INFORMANT<br><b>DAISY ROBERTS</b>  |  | ADDRESS<br><b>65 EDGEHILL ROAD, WARWICK</b>  |  | R. I.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>RESPIRATORY FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) _____<br>(c) _____ |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>_____  |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE       |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> 19 <b>80</b> to <b>1/24</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/24</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Carol L. Bender</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |  | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>1/24/80</b>   |  |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CAROL L. BENDER, MD.</b>   |  | 22e. ADDRESS<br><b>11125 Rockville Pike, Rockville, Md.</b>            |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-28-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PAWTUXET CEMETERY</b>                      |  | 23d. LOCATION<br>CITY OR TOWN<br><b>WARWICK</b>  |  | COUNTY<br><b>RHODE ISLAND</b>  |  | STATE<br><b>RHODE ISLAND</b>   |  |   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>PEARSON'S FUNERAL HOME FALLS CHURCH, VA</b>  |  | ADDRESS<br><b>PEARSON'S FUNERAL HOME FALLS CHURCH, VA</b>              |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |

BP



2-10-1937

RECEIVED

EXHIBIT

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8002136  
REG. NO.

|   |  |  |  |   |  |  |  |  |   |   |  |   |  |
|---|--|--|--|---|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Wiley E. Robnette  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-17-80                         |   |  | 2b. HOUR<br>4:15 P.M.  |  |  |   |   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 10 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Gov't Employee   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Veteran Adm. |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1135 University Blvd |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Oliver Robinette  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Irons  |  |  |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT<br>Mrs. Nora Lannon   |  | ADDRESS<br>509 Crabb Avenue<br>Rockville, Md   |  |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1949 Cardio-respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Hepatic<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Portal Hypertension Blockage |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15'<br>3 min                                    |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>generalized arteriosclerosis  |  |  |  |   |  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24/80, 19 62, to 1/17/80, that (I) (we) lost<br>saw the deceased alive on 1/12/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |   |  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE   |  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>1/17/80                       |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jones P.D.   |  |  |  |   |  | 22e. ADDRESS   |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Jan 20/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Herman Cemetery |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany Maryland   |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Silcox-Merritt Funeral Service.   |  |  | ADDRESS<br>404 Decatur St<br>Cumberland, Md                            |   |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 21 1980  |  |  |   |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |   |  |  |  |  |   |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 80 02137  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>HAZEL S. ROBINSON</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/16/1980</b>  |  |   |  | 2b. HOUR <b>2:55P</b> M  |  |
| 3 SEX <b>Female</b>   |  | 4 RACE <b>Caucasian</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>10 16 XX</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>89</b>  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>WHEATON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>WASHINGTON, D.C.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3051 IDAHO AVENUE, N.W.</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB STONE</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH LARCH</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>040-16-6477</b>  |  | 17. INFORMANT <b>SON</b>   |  | ADDRESS <b>124 COURT HOUSE RD VIENNA, VIRGINIA</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>20 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>See hours</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 51</b> to <b>1/16</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12/14/79</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>William Kurstin MD</b>  |  |  |  | DEGREE <b>MD</b>   |  |  |  | 22c. DATE SIGNED <b>1/16/1980</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Kurstin, MD</b>  |  |  |  | 22e. ADDRESS <b>1145 19th St. NW Wash. DC</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>  |  | 23b. DATE <b>1/18/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>   |  | 23d. LOCATION CITY OR TOWN <b>ALEXANDRIA</b> COUNTY <b>VIRGINIA</b> STATE <b>VIRGINIA</b>    |  | 23e. DATE REC'D. BY REGISTRAR <b>JAN 22 1980</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>   |  |  |  | ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |  |  | 25. REGISTRAR'S SIGNATURE <b>Ruby Kennedy</b>   |  |  |  |

77-11-040

10002 001 01172 251172 00 01172 000

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 1 3 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gertrude P. Roddy</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 7, 1980</b>               |   |  | 2b. HOUR<br>MIN<br><b>11:50 A</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 9, 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>71</b>                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>1001 Rockville Pike #506</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Artist</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Md.</b>   |  |  | 13b. CITY OR TOWN<br><b>Montg.</b>                                       |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>8005 Westover Rd.</b>                         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Palecek</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mathilde Treadon</b> |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-48-9683</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Vincent S. Roddy Same as 13</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral thrombosis due to heart</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>1 yr</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>55</b> , to <b>1/7</b> , 19 <b>80</b> , that (I) (we) lost <b>above</b> the deceased alive on <b>12/28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (If (we) did not view the body after death, so state.)  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Joseph J. Wallace, M.D.</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/8/80</b>                                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph J. Wallace, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>5272 River Rd. Bethesda, Md.</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Jan. 10, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. L. Brady</b>                        |  |  |

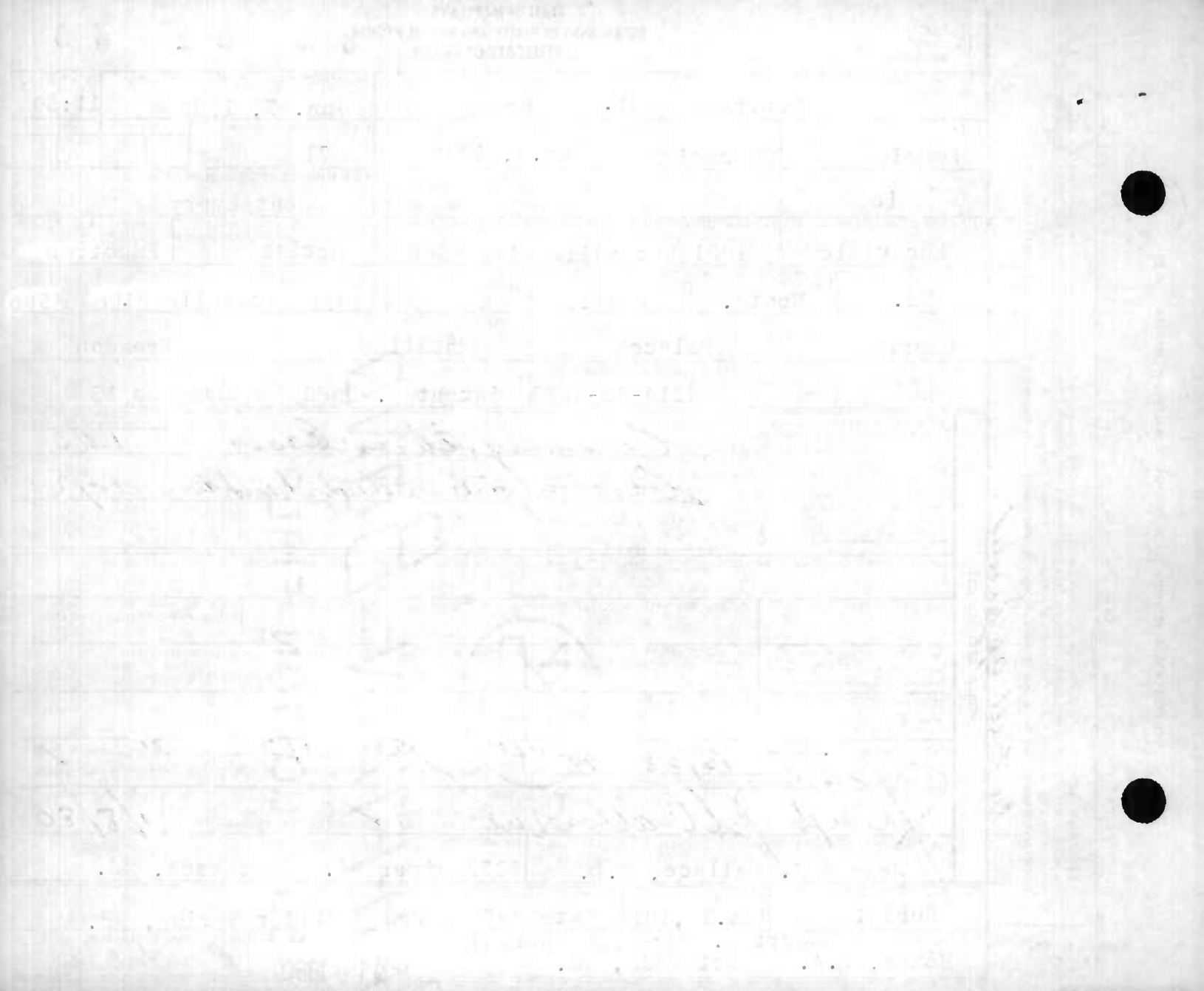
MEDICAL CERTIFICATION

Dr. Paul J. Ballard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |   |  |                            |  |
|--|--|--|--|--|--|---|--|---|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8002139   |  |  |  |   |  |   |  |   |  |                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 20. DATE OF DEATH MONTH DAY YEAR                              |  | 2b. HOUR  |  |                            |  |
| Gerald W. ROGERS   |  |  |  |  |  |   |  | January 8 1980  |  | 1:29A M   |  |                            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                   |  | IF UNDER 24 HRS. HOURS MIN                                |  |                            |  |
| Male   |  | Caucasian  |  | April 19 1935  |  | 44 YRS.   |  |   |  |   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |   |  |                            |  |
| Arkansas   |  | USA  |  |  |  | Montgomery MD   |  |   |  |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |                            |  |
| Bethesda   |  | National Naval Medical Center  |  |  |  |   |  | U. S. Navy  |  |   |  |                            |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |                            |  |
| Virginia   |  | Ann Princess   |  | Virginia Beach   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2252 Tanglewood Drive   |  |   |  |                            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |   |  |   |  |                            |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |   |  |   |  |                            |  |
| Winston Rogers   |  | Theda Pruett   |  |  |  |   |  |   |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |   |  |                            |  |
| Yes  |  | 1957-80  |  | 276 30 0157 Mrs. Joyce Rogers See item 13  |  |   |  |   |  |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated adenocarcinoma of stomach</u>  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |                            |  |
| 1519   |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |   |  |   |  |                            |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |   |  |                            |  |
|  |  | P.M. 19  |  |  |  |   |  |   |  |   |  |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |                            |  |
|  |  |  |  |  |  |   |  |   |  |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 2</u> , 19 <u>79</u> , to <u>Jan. 8</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 8</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  | 22c. DATE SIGNED  |  |                            |  |
| 22b. SIGNATURE <u>C. C. Adkins</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |   |  | Jan. 8, 1980  |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. C. ADKINS, M.D.   |  |  |  |  |  |   |  |   |  | 22e. ADDRESS National Naval Medical Center, Bethesda, Md. |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |                            |  |
| Burial   |  | 1/11/80  |  | Arlington National   |  | Arlington Arlington Va.   |  |   |  |   |  |                            |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR                             |  | 25b. REGISTRAR'S SIGNATURE |  |
| W. W. Chambers Co. Silver Spring, Md.  |  |  |  |  |  |   |  |   |  | JAN 14 1980   |  | <u>Robert H. Bandy</u>     |  |

DECI-MERAS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
 (VR A15 ME (5))  
 15M 7/76

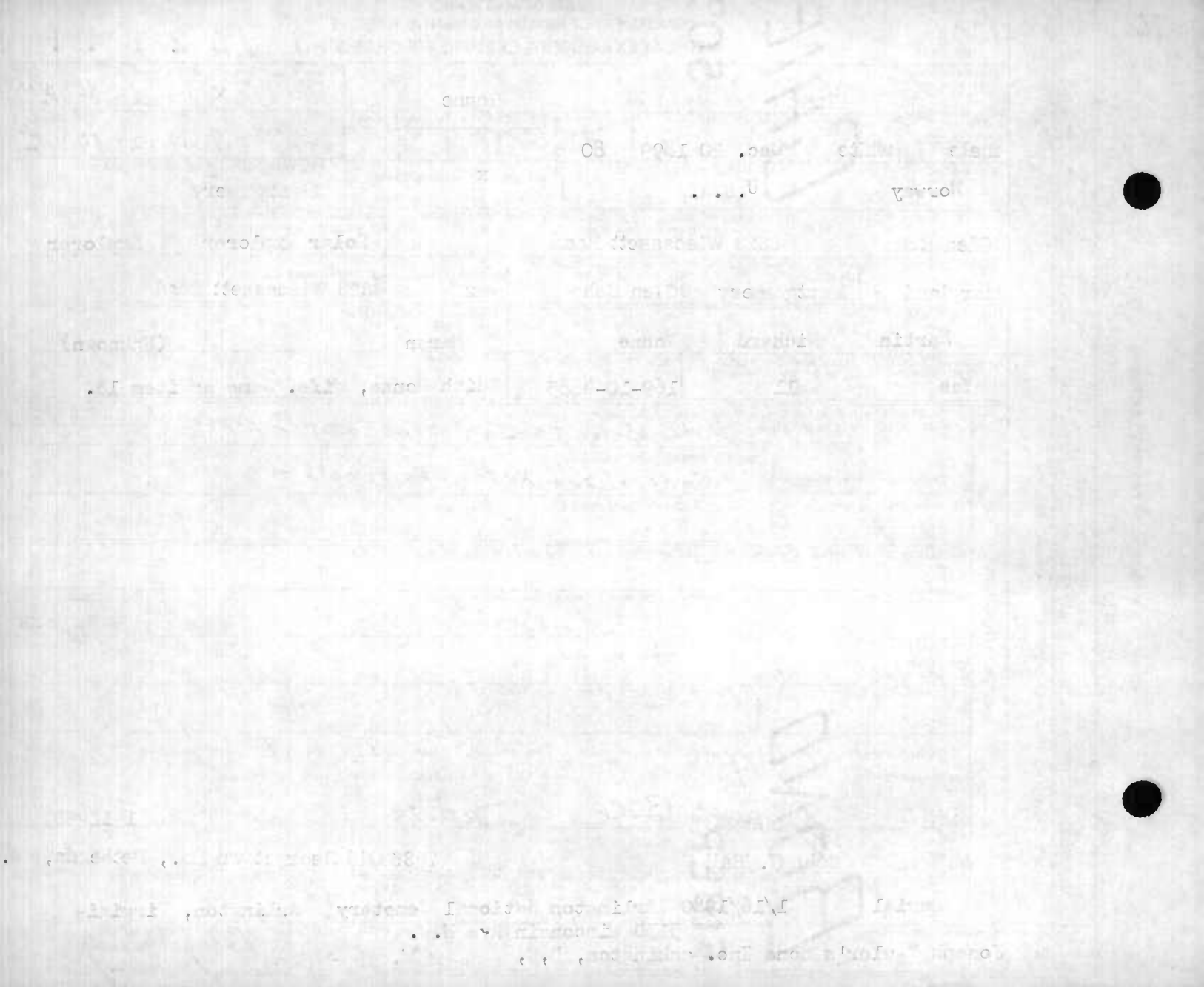
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 02140  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | 7a. DATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>M William Carl Rogers  |  |   |  |   |  |   |  |  |  | KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 12 19 80    |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>March 8, 1941  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>38   |  | IF UNDER 1 YR. MONTHS DAYS   |  | 7b. HOUR<br>M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.  |  | 2c. DATE PRONOUNCED DEAD<br>1 12 19 80   |  | 2d. HOUR<br>5:30 AM   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery County General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Guard  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Washington, D.C.   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3825A W Street, S.E.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Carlisle Rogers   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaretta House  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>yes  |  |   |  | 16b. SOCIAL SECURITY NO.<br>168 34 6694   |  | 17. INFORMANT ADDRESS<br>4227 East Capitol Street, S.E.<br>Mrs. Ernestine Rogers-mother-in-law                      |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>5:00 PM 1 12 19 80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver of auto/fixed object impact |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>8120 Damascus Rd., Montgomery, Md.                                |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE Virginia L. Dolan, M.D.   |  |   |  | TITLE (SPECIFY) Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED 1/14/80  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |   |  | ADDRESS 111 Penn Street   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |   |  | 23b. DATE 1/19/80   |  | 23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.                                |  |   |  |
| 24. FUNERAL DIRECTOR NAME Stewart  |  |   |  | 25a. DATE REC'D. BY REGISTRAR JAN 21 1980   |  |   |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |   |  |



*John H. Thompson*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                               |  |  |  |   |  |  |  | REG. NO. 02141   |  |
|---|--|-------------------------------|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                               |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Finn Ronne</b>  |  |                               |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>1-12-80</b> |  | 2b. HOUR <b>AM</b>   |  |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b>          |  | 5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>20</b> YEAR <b>1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 7c. DATE PRONOUNCED DEAD MONTH <b>Jan</b> DAY <b>12</b> YEAR <b>1980</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Norway</b>   |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                   |  |
| 10. CITY OR TOWN OF DEATH <b>Glen Echo</b>  |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6323 Wiscasset Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Polar Explorer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Explorer</b>                        |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                               |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>6323 Wiscasset Road</b>   |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b> |  | 13c. CITY OR TOWN <b>Glen Echo</b>   |  |   |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Martin</b> MIDDLE <b>Richard</b> LAST <b>Ronne</b>   |  |                               |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Maren</b> MIDDLE <b>(Unknown)</b> LAST <b>(Unknown)</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                               |  | 16b. SOCIAL SECURITY NO. <b>WW1</b>  |  | 17. INFORMANT <b>Edith Ronne, Wife. Same as item 13.</b>  |  | ADDRESS  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                               |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                               |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                               |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |                               |  | TITLE (SPECIFY) <b>Deputy</b>  |  |   |  | DATE SIGNED <b>1-12-80</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |  |                               |  | ADDRESS <b>7936 Old Georgetown Rd., Bethesda, Md.</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                               |  | 23b. DATE <b>1/16/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN <b>Arlington, Virginia</b> COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Lawler's Sons Inc.</b> ADDRESS <b>Washington, D.C.</b>  |  |                               |  | DATE REC'D. BY REGISTRAR <b>JAN 16 1980</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |   |  |  |
|--|--|--|---|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO. 8002142   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MOLLIE ROSENBLUM</b>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 11, 1980</b>           |  |   | 2b. HOUR<br><b>9:35 a.m.</b>  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>? ? 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. COUNTY<br><b>Montgomery</b>                                   |  | 13c. CITY OR TOWN<br><b>Sil. Spring</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL LEFF</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BASHA WOLFSON</b> |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-7306</b>   |   | 17. INFORMANT ADDRESS<br><b>Philip Rosenbloom; 1508 Constance St. Silver Spring, Md.</b>  |  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 10</b> , 19 <b>80</b> , to <b>JAN 11</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>JAN 10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>John J. Merendino</b>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Jan 11, '80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN J. MERENDINO, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>11620 Kemp Mill Road, Silver Spring, Md.</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1-13-1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anshe Lubovitz Cem.</b>   |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Millville, Pennsylvania</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels;</b>  |  |  | ADDRESS<br><b>1170 Rockville Pike</b>                               |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McCready</b>  |  |  |



101

11/10/1914  
11/10/1914

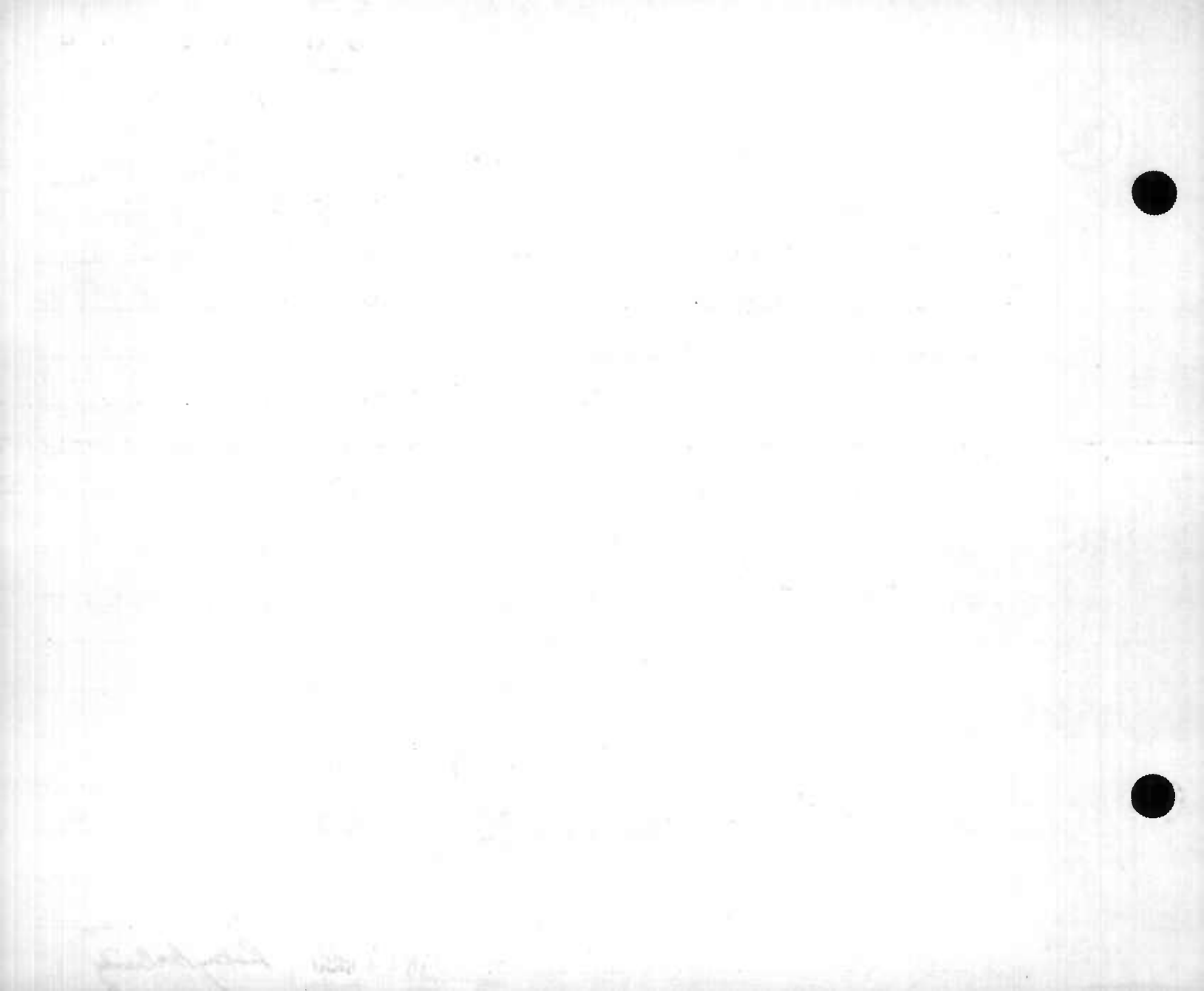
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                             |  |                                 |  |  |                                   |                                     |  | 80002143  |  |   |  |  |                                  |  |  |  |  |
|---|--|-----------------------------|--|---------------------------------|--|--|-----------------------------------|-------------------------------------|--|---|--|---|--|--|----------------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                             |  |                                 | REG. NO.   |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |                             |  |                                 | 2a DATE OF DEATH   |  |                                   |                                     |  | 2b HOUR   |  |   |  |  |                                  |  |  |  |  |
| FIRST MIDDLE LAST<br>Harry "I" Rubinstein   |  |                             |  |                                 | MONTH DAY YEAR<br>1 7 80   |  |                                   |                                     |  | 12 <sup>02</sup> P.M.   |  |   |  |  |                                  |  |  |  |  |
| 3 SEX   |  | 4 RACE                      |  | 5 DATE OF BIRTH                 |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)    |                                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |  |  |                                  |  |  |  |  |
| Male  |  | Caucasian                   |  | MONTH DAY YEAR<br>Apr. 14, 1905 |  |  | 74 YRS.                           |                                     |  | MONTHS DAYS   |  | HOURS MIN.  |  |  |                                  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY? |  |                                 | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |   |  |  |                                  |  |  |  |  |
| District Columbia   |  | USA                         |  |                                 |  |  |                                   | Montgomery MD                       |  |   |  |   |  |  |                                  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  |                             |  |                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |                                   |                                     |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |   |  |  | 12b KIND OF BUSINESS OR INDUSTRY |  |  |  |  |
| Takoma Park   |  |                             |  |                                 | Washington Adventist Hospital  |  |                                   |                                     |  | Owner   |  |   |  |  | Liquor Store                     |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |                                 |  |  |                                   |                                     |  | 13d INSIDE CITY LIMITS?   |  |   |  |  | 13e STREET ADDRESS               |  |  |  |  |
| 13a STATE 13b COUNTY 13c CITY OR TOWN<br>Maryland Montgomery Chevy Chase  |  |                             |  |                                 |  |  |                                   |                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |   |  |  | 2308 Blaine Drive                |  |  |  |  |
| 14 FATHER'S NAME  |  |                             |  |                                 | 15 MOTHER'S MAIDEN NAME  |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| FIRST MIDDLE LAST<br>Solomon ----- Rubinstein   |  |                             |  |                                 | FIRST MIDDLE LAST<br>Bessie --- Baylin   |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |                             |  |                                 | 16b SOCIAL SECURITY NO   |  |                                   |                                     |  | 17 INFORMANT ADDRESS  |  |   |  |  |                                  |  |  |  |  |
| No N/A  |  |                             |  |                                 | 577-09-0715A   |  |                                   |                                     |  | Frances Rubinstein, 2308 Blaine Dr., Maryland                                 |  |   |  |  |                                  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Stem Infarction</u>  |  |                             |  |                                 |  |  |                                   |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>23 days</u>                |  |   |  |  |                                  |  |  |  |  |
| 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |                             |  |                                 |  |  |                                   |                                     |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Disease</u>           |  |   |  |  | 5 years                          |  |  |  |  |
|   |  |                             |  |                                 |  |  |                                   |                                     |  | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>         |  |   |  |  | 5 years                          |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><u>Myocardial Infarction</u>  |  |                             |  |                                 |  |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| 19a DATE OF OPERATION   |  |                             |  |                                 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                   |                                     |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |                                  |  |  |  |  |
|   |  |                             |  |                                 |  |  |                                   |                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |                                  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                             |  |                                 | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                   |                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |                                  |  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                             |  |                                 | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                   |                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |                                  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8/1/80</u> , 19 <u>79</u> , to <u>1/7</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased <u>live on</u> <u>1/6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                             |  |                                 |  |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| 22b SIGNATURE   |  |                             |  |                                 | DEGREE   |  |                                   |                                     |  | 22c DATE SIGNED   |  |   |  |  |                                  |  |  |  |  |
| <u>Keith M. Lindgren MD</u>   |  |                             |  |                                 |  |  |                                   |                                     |  | 1/7/80  |  |   |  |  |                                  |  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                             |  |                                 | 22e ADDRESS  |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| <u>Keith M. Lindgren</u>  |  |                             |  |                                 | <u>WAH</u>   |  |                                   |                                     |  |   |  |   |  |  |                                  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                             |  |                                 | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY |                                     |  | 23d LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |                                  |  |  |  |  |
| Burial  |  |                             |  |                                 | 1-10-80  |  | B'Nai Israel Cem.                 |                                     |  | Oxon Hill, P. Geo., Maryland  |  |   |  |  |                                  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS  |  |                             |  |                                 |  |  |                                   |                                     |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE                        |  |   |  |  |                                  |  |  |  |  |
| DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.  |  |                             |  |                                 |  |  |                                   |                                     |  | JAN 14 1980 <u>Keith M. Lindgren</u>  |  |   |  |  |                                  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |                   |  |   |   |   | REG. NO. 8002144   |  |  |  |
|---|--|--|--|---|-------------------|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST<br>EVA  | MIDDLE<br>SYBILLA | LAST<br>RUTH   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 23, 1980   |   |   | 2b. HOUR<br>12:13/p.m.   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 29, 1899   |                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4921 Chevy Chase Blvd. |  |   |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress                     |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Garment   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |                   |  |   |   |   | 13a. STREET ADDRESS<br>4921 Chevy Chase Blvd.  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Chevy Chase  |                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Earle Ruth   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Hoffert  |                   |  |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>162-07-2014   |                   | 17. INFORMANT<br>Edna A. Priolo  |   |   | ADDRESS<br>Same as 13   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) Hepatic Coma - Liver Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Hepatorenal Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF (c) Cryptogenic Cirrhosis                             |  |  |  |   |                   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hours<br>2 weeks  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |                   |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 11/21 19 79, to 11/22 19 80, that (I) (we) last saw the deceased alive on 11/16 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |   |                   |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Stuart Danovitch  |  |  |  |   |                   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>1/23/80   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stuart Danovitch   |  |  |  |   |                   | 22e. ADDRESS<br>4400 Jenifer St., N.W.<br>Washington, D.C. 20015   |   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>Jan 26, 1980   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Hellertown Union Cemetery  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hellertown, Pennsylvania |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Capitol Funeral Service  |  |  |  |   |                   | ADDRESS<br>Fairfax, Va.  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1980                              |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |

MEDICAL CERTIFICATION



|      |      |      |      |      |      |
|------|------|------|------|------|------|
| 1900 | 1901 | 1902 | 1903 | 1904 | 1905 |
| 1906 | 1907 | 1908 | 1909 | 1910 | 1911 |
| 1912 | 1913 | 1914 | 1915 | 1916 | 1917 |
| 1918 | 1919 | 1920 | 1921 | 1922 | 1923 |
| 1924 | 1925 | 1926 | 1927 | 1928 | 1929 |
| 1930 | 1931 | 1932 | 1933 | 1934 | 1935 |
| 1936 | 1937 | 1938 | 1939 | 1940 | 1941 |
| 1942 | 1943 | 1944 | 1945 | 1946 | 1947 |
| 1948 | 1949 | 1950 | 1951 | 1952 | 1953 |
| 1954 | 1955 | 1956 | 1957 | 1958 | 1959 |
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| 1966 | 1967 | 1968 | 1969 | 1970 | 1971 |
| 1972 | 1973 | 1974 | 1975 | 1976 | 1977 |
| 1978 | 1979 | 1980 | 1981 | 1982 | 1983 |
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1996 1997 1998 1999 2000 2001

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8002145

1- FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nora Ryan</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 20 1980</b>   |  | 2b. HOUR<br><b>11:55 AM</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 7, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Rockville</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>10201 Grosvenor Place</b> |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Murphy</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Dean</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>184-20-6070</b>  |  | 17. INFORMANT<br><b>Laura Ryan</b> ADDRESS <b>Same as 13</b>         |  |

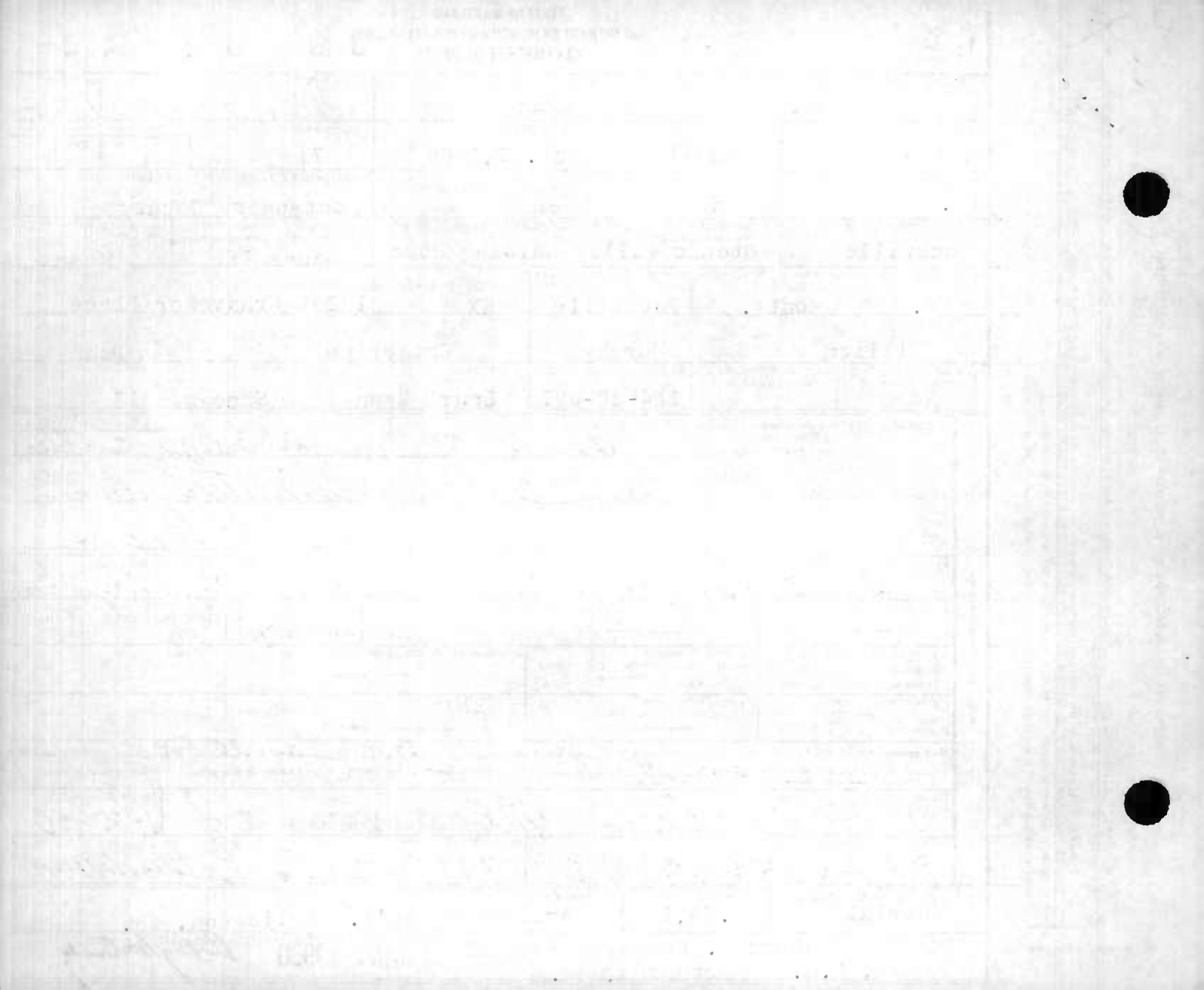
## MEDICAL CERTIFICATION

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema Sudden</b><br>4409<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Severe Generalized Arteriosclerosis</b><br>(c) <b>Arteriosclerosis Obliterans</b>    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bilateral Amputated Lower Extremities Chronic Renal Disease</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b> P.M. <b>19</b>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>1970</b> , to <b>Jan 20</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 14</b> , 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>P.P. Andrews M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><b>1-20-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P.P. ANDREWS M.D.</b>  |  | 22e. ADDRESS<br><b>4977 Bethesda Rd. Bethesda, Md.</b>                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 23, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l.</b>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Va.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b>      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1980</b>  |  |
| 25b. REGISTRAR'S NAME<br><b>Robert A. Pumphrey</b>   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSE R SACKETT  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JAN. 30, 1980 |  |  | 2b. HOUR<br>3:25A  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 16, 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | 7. UNDER 1 YEAR MONTHS DAYS<br># UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Rhode Island  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>D. C.  |  | 13b. COUNTY<br>N/A  |  | 13c. CITY OR TOWN<br>Washington   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>4100 Cathedral Ave NW, #704   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Albert --- Rosenberg  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 16c. 578-38-1567A   |   | 17. INFORMANT ADDRESS<br>Stanley Scherr, 7001 Hopewood, Silver Spring Maryland   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u><br>2000<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) <u>Histiocytic lymphoma, stomach</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>2 mos. |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Postoperative gastric resection with colocutaneous fistula</u>  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br>11/26/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>lymphoma stomach  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> 19 <u>79</u> to <u>1/29/</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1/29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br>Stanley M. Kirson  |  |   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/30/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley M. Kirson   |  |   |  | 22e. ADDRESS<br>8830 Cameron St. Silver Spring, Md.   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-1-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Adas Israel Cem.  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D. C.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 05 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>Hofing McCreedy  |  |  |  |

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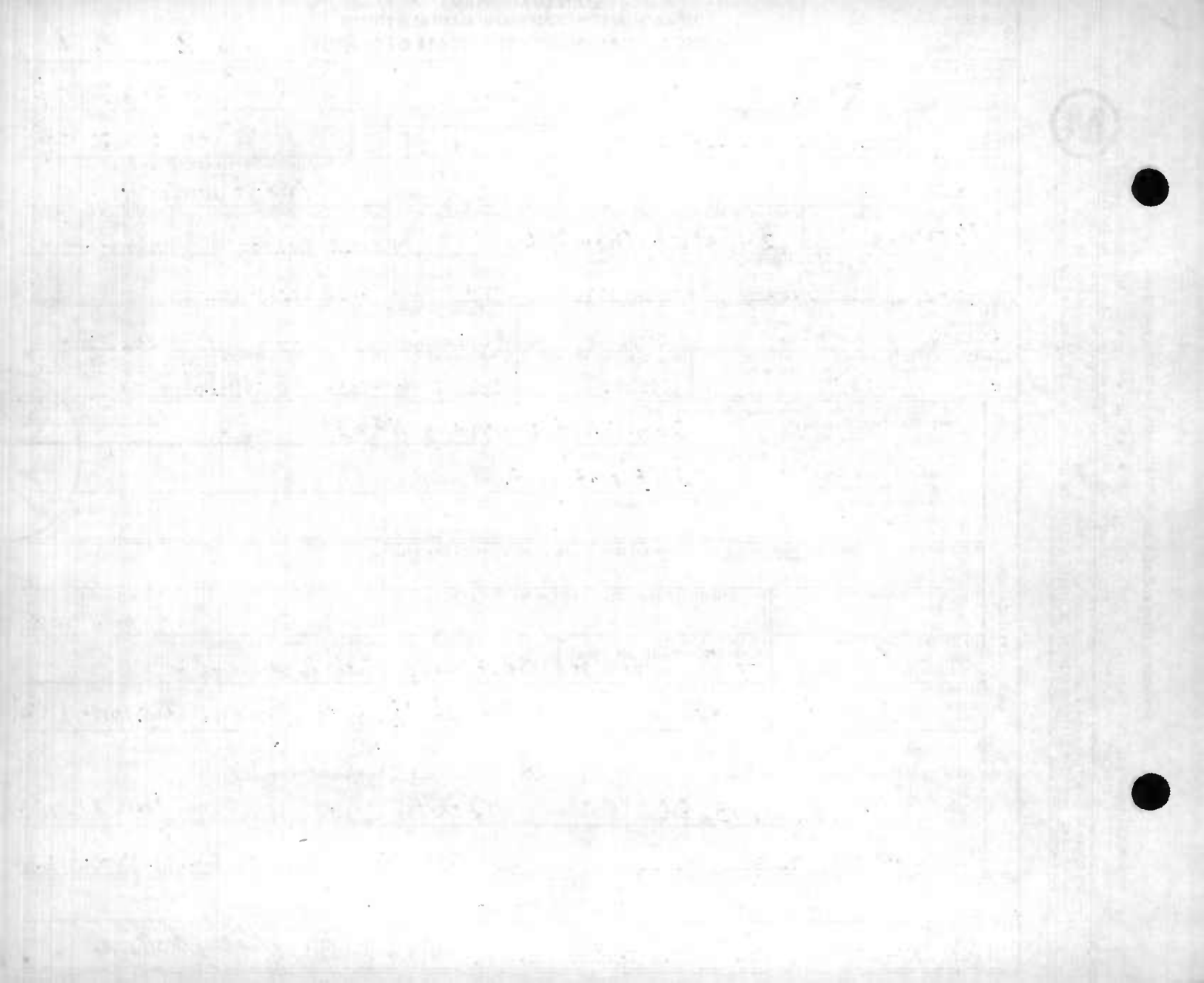
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                             |   |   |   |                  |  |                          |  |  | REG. NO. 02147  |                                |
|---|-----------------------------|---|---|---|------------------|--|--------------------------|--|--|---|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert D. Sage</b>  |                             |   |   |   |                  |  |                          |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br><b>1-21 1980</b> | 2b. HOUR<br>10<br><b>7 P M</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 15, 1956</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>24 YRS.</b> | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Jan 21 1980</b>                             | 2d. HOUR<br><b>7 P M</b> |  |  |   |                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |                          |  |  |   |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Potomac</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2415 Chatham Pl.</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>         |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Transport</b>  |  |   |                                |
| 13a. STATE<br><b>Maryland</b>   |                             | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>   |                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          | 13e. STREET ADDRESS<br><b>12022 Ashby Drive</b>  |  |   |                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanley ----- Sage</b>   |                             |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Selma ----- Zeitlin</b>   |                  |  |                          |  |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |   | 17. INFORMANT<br><b>Michael Benjamin</b>  |                  | ADDRESS<br><b>Toronto, Canada 2401 Steeles Ave.</b>  |                          |  |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9540 Gun Shot Wound of Head.</b><br>IMMEDIATE CAUSE (a) <b>Self inflicted.</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Self inflicted.</b><br>(c) <b>Self inflicted.</b>  |                             |   |   |   |                  |  |                          |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |   |   |   |                  |  |                          |  |  |   |                                |
| 19a. DATE OF OPERATION  |                             |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |  |                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |   |                                |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>7 P.M. 1-21 1980</b>   |                             |   |   | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>7 P.M. 1-21 1980</b>   |                  |  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot self with hand gun.</b> |  |   |                                |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                             |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>House</b>   |                  |  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2415 Chatham Pl. Potomac. Montgomery. Md.</b>            |  |   |                                |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |   |   |   |                  |  |                          |  |  |   |                                |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |                             |   |   | TITLE (SPECIFY)<br><b>Deputy</b>  |                  |  |                          | DATE SIGNED<br><b>Jan. 21, 1980</b>  |  |   |                                |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John G. Ball, M. E.</b>   |                             |   |   | ADDRESS<br><b>7936 Old Georgetown Rd., Bethesda, Md.</b>  |                  |  |                          |  |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                             |   |   | 23b. DATE<br><b>1-24-80</b>   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Blossom Cemetery</b>                           |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Toronto, Canada</b>   |  |   |                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DANZANSKY-GOLDBERG MEM. CHAP., Rockville, Md.</b>  |                             |   |   |   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>  |                          | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>  |  |   |                                |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 0 2 1 4 8<br>REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| Celia  |  | ---  |  | Salov   |  |   |  | Jan. 21, 1980   |  | 12:55P M   |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7 UNDER 1 YEAR MONTHS DAYS  |  | 7 UNDER 24 HRS HOURS MIN                               |  |
| Female   |  | Caucasian  |  | Oct. 10, 1881   |  | 98 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Russia   |  | USA  |  |   |  | Montgomery MD   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| Chevy Chase  |  | Chevy Chase Nursing Center   |  | Homemaker   |  | Home  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                                    |  |
| D. C.  |  | N/A  |  | Washington  |  |   |  | 3003 Van Ness St., N. W.  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |   |  |   |  |  |  |
| Sol Solomon  |  | Snitzer  |  | Kate Sloan  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |   |  |   |  |  |  |
| No   |  | N/A  |  | 577-42-3184A Julius Bernstein, 3303 Shirley Ln. Maryland  |  |   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cessation respirations   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes |  |
| 4349 DUE TO, OR AS A CONSEQUENCE OF (b) cerebral infarction  |  |  |  |   |  |   |  |   |  | 2 weeks  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) gen arteriosclerosis  |  |  |  |   |  |   |  |   |  | 20 years   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 1/22/80, 19, that (I) (we) lost saw the deceased alive on 18 Jan 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |   |  | 22c. DATE SIGNED 1/22/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |  |  |
| DR. MILTON GUSACK  |  | 1100 22nd St., N. W. Washington, D. C.   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| Burial   |  | 1-23-80  |  | Mt. Jacob Cemetery  |  | Philadelphia, Pennsylvania  |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| DANZANSKY-GOLDBERG MEM. CHAP.  |  | Rockville, Md.   |  | JAN 28 1980   |  | [Signature]   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after the death. Pages 1 and 2 should be removed from the certificate and placed in the container with the body for removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nellie Louise</b>   |  | LAST<br><b>SALTS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 15 1980</b>   |  | 2b. HOUR<br><b>11:50A</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 29 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Florida</b>   |  |   |  | 13b. COUNTY<br><b>Lake</b>  |  | 13c. CITY OR TOWN<br><b>Leesburg</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Milton D. Bayless</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Taylor</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>290 16 1268</b>   |  | 17. INFORMANT ADDRESS<br><b>Marion Salts See item 13</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>End stage renal disease complicated by acute bronchopneumonia</b><br><b>5939</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 21</b> , 19 <b>79</b> , to <b>Jan. 15</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan. 15</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death                                    |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Michael J. Duran</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>Jan. 16 1980</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael J. Duran, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 19, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lady Lake Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lady Lake, Florida</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Capitol Funeral Services Fairfax, Virginia</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hickey McCreedy</b>  |  |





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Page 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

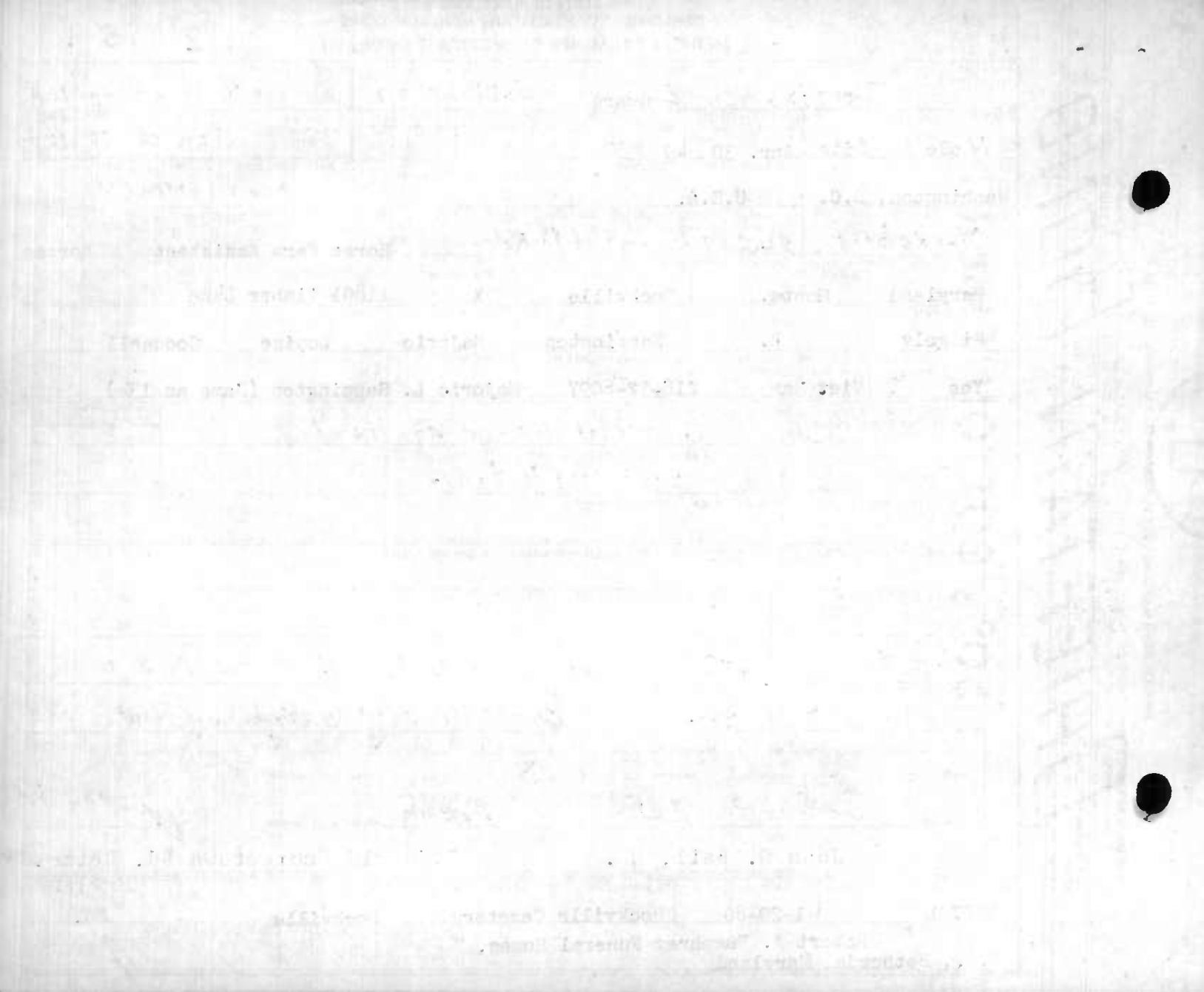
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |  |  |
|---|--|---|--|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO. 8002150   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Edith C. Sanders  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>Jan 7 1980 4:45 PM  |  |   |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Apr. 9 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS                                |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>411 Silver Spring Avenue, |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.             |  |  |
| 13a. STATE<br>Maryland  |  |   |  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spr   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willis Obenchein Sanders   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen W. Klody   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT (sister) 5429 32nd St., N.W.   |  | Ruth S. Orlosdy-Washington, DC   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4409 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>? |  |   |  |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Chronic Asthma (Bronchial)</u>   |  |   |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>48</u> to <u>7 Jan</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Dec 29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br>William D. Aud, MD  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>1/7/80                                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William D. Aud, MD   |  |   |  |  | 22e. ADDRESS<br>9006 Colesville Rd., S.S. Md.  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 10-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D.C.              |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |  |  |
| 8434 Ca. Ave., S.S. Md.   |  |   |  |  |  |  |   |   |  |  |

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |  |   |  |   |   |  |  |
|---|-------------------------|---|---|---|--|---|--|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>FOR<br/>1- STATE REGISTRAR</p> </div> <div> <p>REG. NO. <b>02151</b></p> </div> </div>  |                         |   |   |   |  |   |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Douglas - Edward Sappington</b>  |                         |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTI. MATED <input checked="" type="checkbox"/> <b>1-24-80</b>                                 |  |   | 2b. HOUR <b>10:30 P.M.</b>  |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Apr.</b> DAY <b>30</b> YEAR <b>49</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>30</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br><b>Jan 25 1980</b>  |  |   | 2d. HOUR <b>12:15 P.M.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clarksburg</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>24239 Burnt Hill Rd.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Horse Farm Assistant</b>                              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Horses</b>                                |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |   |   |   |  |   |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Montg.</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  | 13e. STREET ADDRESS<br><b>11801 Timber Lane</b>                                     |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Ridgely</b> MIDDLE <b>B.</b> LAST <b>Sappington</b>   |                         |   |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Majorie</b> MIDDLE <b>Louise</b> LAST <b>Goodsell</b>                                |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         |   |   | 16b. SOCIAL SECURITY NO.<br><b>218-52-8097</b>  |  | 17. INFORMANT ADDRESS<br><b>Majorie L. Sappington (Same as 13e)</b>   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head.</b><br>9550<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause</u> last.<br>(b) <b>Self inflicted.</b><br>(c) <b></b>   |                         |   |   |   |  |   |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |   | 21b. TIME OF INJURY<br>HOUR <b>10:30</b> MONTH <b>1</b> DAY <b>24</b> YEAR <b>1980</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot self with 22 Cal. Powl. gun.</b> |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |  | 21i. LOCATION<br>STREET <b>24239 Burnt Hill Rd.</b> CITY OR TOWN <b>Clarksburg</b> COUNTY <b>Mont.</b> STATE <b>MD.</b>   |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |                         |   |   | TITLE (SPECIFY) <b>Deputy</b> M.D.  |  |   |  | MEDICAL EXAMINER  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, MD.</b>  |                         |   |   | ADDRESS <b>7936 Old Georgetown Rd. Bethesda Md.</b>   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |                         |   |   | 23b. DATE <b>1-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Md.</b> STATE <b>Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>  |                         |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1980</b>   |  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |       |
|---|--|--|--|--|--|---|--|--|-------|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8002152   |  |  |  |   |  |  |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS Peter SARELAS</b>   |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 26, 1980</b>                                  |  | 2b. HOUR<br><b>5:45p<sub>M</sub></b>   |       |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25, 1908</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Saco, Maine</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                              |  |  |       |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Production</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Navy Yard Superintendent</b>   |       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Washington</b> 13b. COUNTY <b>Skagit</b> 13c. CITY OR TOWN <b>LaConner</b>   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>42-Skokomish Way</b>   |       |
| 14 FATHER'S NAME<br>FIRST <b>Peter</b> MIDDLE <b>-</b> LAST <b>Sarelas</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Delia</b> MIDDLE <b>-</b> LAST <b>Evangelia</b>  |  |   |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-44-4223</b>   |  | 17 INFORMANT<br><b>Ruth J. Sarelas-Wife</b>  |  |   |  | ADDRESS<br><b>Same as # 13</b>   |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4340</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Thrombotic Stroke</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |  |  |   |  |  |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY   | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 15</b> , 19 <b>80</b> , to <b>JAN 25</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>JAN 26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |       |
| 22b. SIGNATURE<br><b>Michael A. Bolognese</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>1-27-80</b>   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael A. Bolognese M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>19261 Montgomery Village Ave<br/>G-23<br/>Gaithersburg, Md. 20760</b>   |  |   |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Jan. 27, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Washington, D.C.</b>  |  | COUNTY   | STATE |
| 24 FUNERAL DIRECTOR<br><b>J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kathy McCreedy</b>   |  |  |       |

J. M. Lee's Home Co. 300-4th St., Wash., D.C. 20002  
 Operation Jan. 27, 1960 Lee's Laboratory Washington, D.C.

No 210-44-4523 with J. Lee's wife same as 13

Peter - Garcia Delia - Evan-elia

Washington Strait Lagoon x 4-300000000

City

[Department of Health]

Navy Y. [Department of Health]

Saco, Maine

United States

xx

July 25, 1908

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Peter

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

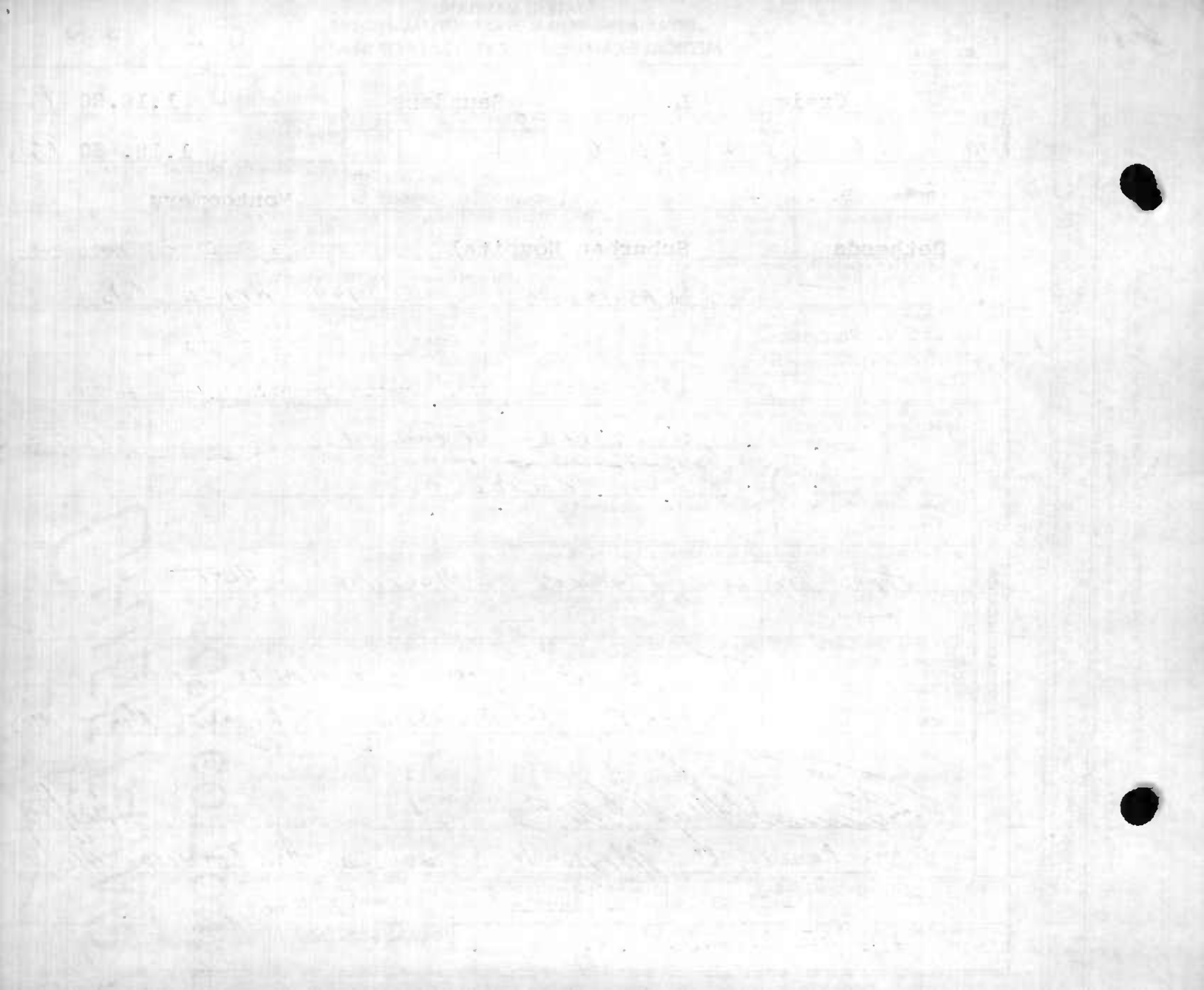
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 2 1 5 3  
REG. NO.

|  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
|--|---------|--|--|---|--|---|--|----------------------------|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR  |  |
| Craig L. Saunders  |         |  |  |   |  |   |  | 1.18.80                    |  |  |  | 921 PM  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.           |  | 2c. DATE<br>PRONOUNCED<br>DEAD   |  | 2d. HOUR  |  |
| M  | 26      | 5 20 53  |  | 26 YRS.   |  | MONTHS DAYS HOURS MIN   |  |                            |  | 1.18.1980  |  | 921 PM  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |  |  |  |   |  |
| Washington, D.C.   |         | USA  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Montgomery  |  |                            |  |  |  | MD  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                            |  |  |  |   |  |
| Bethesda   |         | Suburban Hospital  |  | Programmer Analyst  |  | Gen. Electric   |  |                            |  |  |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |  |  |   |  |
| DC   |         |  |  | WASHINGTON  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3144 APPLE RD              |  |  |  |   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                            |  |  |  |   |  |
| Emmett V. Saunders   |         | Rosa G. Saunders   |  |   |  |   |  |                            |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                            |  |  |  |   |  |
| Unk  |         | 578-72-4336  |  | Mrs. Alvetta Smythe/wife/same as 13e  |  |   |  |                            |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |                            |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) MULTIPLE TRAUMA  |         |  |  |   |  |   |  |                            |  |  |  | ACUTE   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| (b) AUTO ACCIDENT  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| (c)  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| HEAD BASILAR FRACTURES + MULTIPLE CHEST  |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                            |  |  |  |   |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |   |  |                            |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |                            |  |  |  |   |  |
|  |         | 9:00 P.M. 1 18 1980  |  | SKIDDED INTO OPPOSITE LANE  |  |   |  |                            |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                       |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |  |   |  |                            |  |  |  |   |  |
|  |         | STREET   |  | GA AVE + SEMINARY RD SILVER SPRING MONT. MD   |  |   |  |                            |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held in  |         |  |  |   |  |   |  |                            |  |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |                            |  |  |  |   |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | DATE<br>SIGNED  |  |   |  |                            |  |  |  |   |  |
| Francis C. Mayle Jr.   |         | Dept   |  | 1/18/80   |  |   |  |                            |  |  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |                            |  |  |  |   |  |
| Francis C. Mayle Jr.   |         | 8200 Wisconsin Ave Bethesda MD   |  |   |  |   |  |                            |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                     |  | STATE  |  |   |  |
| Burial   |         | 1-23-80  |  | Ft. Lincoln   |  | Brentwood,  |  |                            |  | Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                            |  |  |  |   |  |
| John T. Rhines Co<br>3015 12th St., N.E., D. C.  |         | JAN 24 1980  |  | [Signature]   |  |   |  |                            |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |                                |   |   |  |
|---|--|--|--|---|--|--|--------------------------------|---|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 80 02154  |  |   |  |  |                                |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>David D. Saunders  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 11, 1980 |  |                                | 2b. HOUR<br>1:34 <sup>P</sup> M   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 25, 1933   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 <sup>RS</sup>                                  |                                | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                       |                                |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NIH, Clinical Center, Bethesda, Md |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DATA PROCESSING     |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>SYSTEMS ANALY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>Maryland   |  |  |  |   | 13c. COUNTY<br>Montgomery                            |  | 13d. CITY OR TOWN<br>Rockville |   | 13e. STREET ADDRESS<br>4111 Bel Pre Rd. 20853 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS D. SAUNDERS   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARIE AMENDT   |  |   |  |  |                                |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>KOREA  |  | 17. INFORMANT<br>Mrs. Jean Saunders (NOK)   |  | ADDRESS<br>Same as Above   |                                |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of bladder</u><br><u>1889</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Local invasion and multiple distant</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Metastases</u>  |  |  |  |   |  |  |                                |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |                                |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 29</u> 19 <u>79</u> , to <u>January 11</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 11, 1980</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |  |  |   |  |  |                                |   |   |  |
| 22b. SIGNATURE<br><u>Daniel B. Rubinstein MD</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-11-80  |                                |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel B. Rubinstein   |  |  |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md 20205  |  |  |                                |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1-16-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN CEMETERY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONTG. MD.                  |                                |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A   |  |  |  | ADDRESS<br>ROCKVILLE MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1980   |                                | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |

MEDICAL CERTIFICATION

·人·志·

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002155

REG. NO.

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Patrick None Savoca, Jr.   |  |   | MONTH DAY YEAR<br>1/22/80  |   |  | 6:30a <sub>M</sub>   |  |  |
| 3. SEX<br>Male  | 4. RACE<br>white   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2- 15- 73   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>6 yrs.                                |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3308 Camden St. Wheaton |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A                             |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Mont.   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13c. CITY OR TOWN<br>Wheaton  |  |   | 13e. STREET ADDRESS<br>3308 Camden St.                                   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Ann Figlioizzi |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-90-6329   |   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Margaret Savoca same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>probable Pelizaeus-Merzacher Disease</u><br>3300<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Mother<br>2/15/73 -<br>1/21/80   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |  |
| Possible Urinary Tract Infection & Bronchitis   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/73 to 1/21/80, that (I) (we) lost saw the deceased <u>alive</u> on 1/21/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br>George R. Spence M.D.   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/22/80  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George R. Spence M.D.  |  |   |  |   |  | 22e. ADDRESS<br>1515 Highland Drive S.S. MD 20910  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>1/24/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS, SILVER SPRING, MD   |  |   | ADDRESS<br>500 UNIV. BLVD. W.  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1980   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24  
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002156  
REG. NO.

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES J SAXON</b>      |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/28/80</b> |   |  | 2b. HOUR<br><b>5<sup>30</sup> P.M.</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/13/14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Toledo, Ohio</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONT. COUNTY</b> MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kensington Gardens N. Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LAWYER</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>       |  |
| 13a. STATE<br><b>MARYLAND</b>                                    |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN<br><b>CHENY CLIFF</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4708 FAIRSTONE AVE.</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL J. SAXON</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE FRANCES MULHANNEN</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-48-7940</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>DOROTHY B. SAXON SAME AS #13</b> |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Alzheimer's disease</b><br><b>3310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerosis, cerebral</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>same</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5-6 years</b> |  |
|---|--|---|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1974</b> , 19____, to <b>28 Jan</b> , 19 <b>78</b> , that (1) (we) last saw the deceased alive on <b>18 Jan</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Charles E. Keegan</b>   |  | 22c. DATE SIGNED<br><b>28 Jan 80</b>  |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES E. KEEGAN JR. M.D.</b>  |  |
| 22e. ADDRESS<br><b>3752 BENJON ST. N.W. WASH. D.C.</b>   |  | 22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                              |  | 23b. DATE<br><b>1-31-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATES HAVEN CEM.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WASH. D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John F. DeVol DEVOL FUNERAL HOME WASH. D.C.</b> |  |                             |  | 25. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>1500</b> <b>Sandy</b> |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002157

REG. NO.

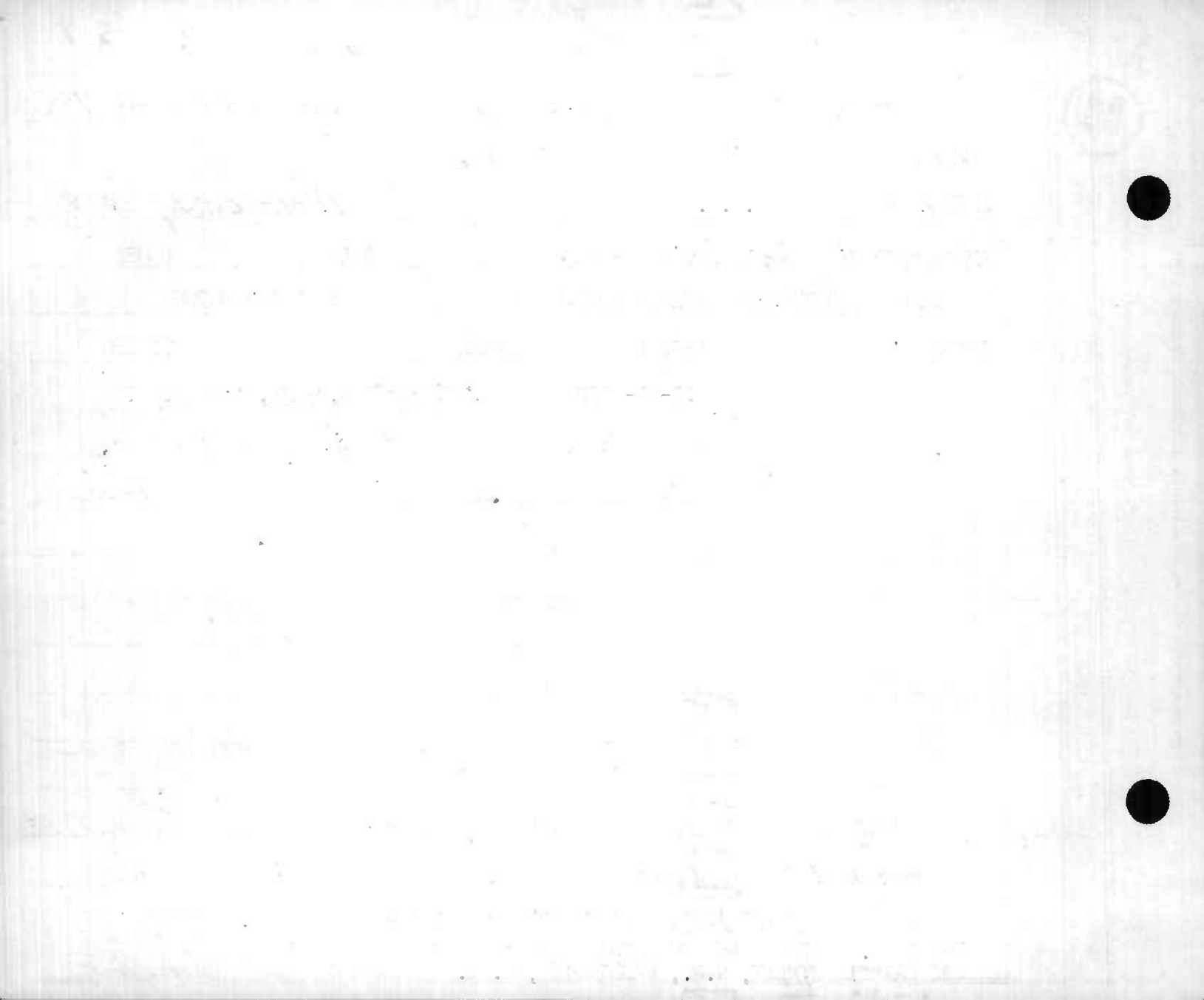
|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert Seidel</b>                                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 17 1980</b> |   |  | 2b. HOUR<br><b>7:08 AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JANUARY 18, 1912</b>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOES</b>               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1401 DUBLIN DRIVE</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC SEIDEL</b>                           |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH TIGLER</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577-07-6777</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MARJORIE SEIDEL, wife, same as #13</b>   |  |   |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - brain stem lesion (infarct)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis, generalized</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unknown</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 days</b> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 28, 1963</b> , to <b>January 17, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>January 17, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Clara H. Traum MD</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>January 17 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AARON H. TRAUM MD</b>   |  | 22e. ADDRESS<br><b>8915 Georgia Ave. Silver Spring Maryland</b>        |  |  |  |   |  |

|   |  |                               |  |   |  |  |  |
|---|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/18/1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEMORIAL GARDEN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FALLS CHURCH VIRGINIA</b> |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard B. Brady</b>                      |  |

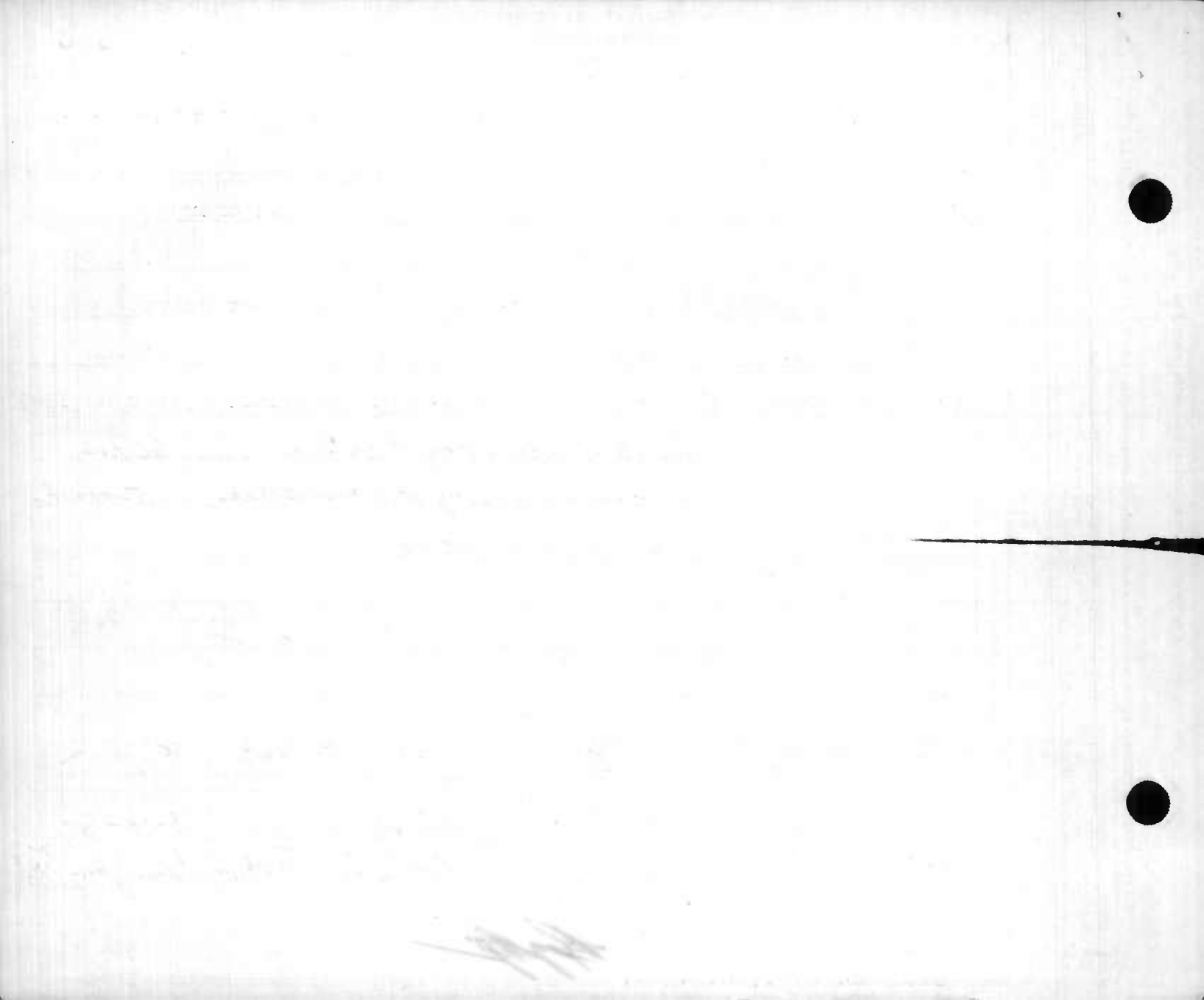


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8002158   |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FRANK C. SENGSTACK  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-4-80  |  | 2b. HOUR<br>2:15 AM  |  |
| 3. SEX<br>M  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>NO <input type="checkbox"/>                              |  | 13e. STREET ADDRESS<br>302 Hillmoor Drive,  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry E. Sengstack   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Adamson   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none  |  | 17. INFORMANT<br>(wife) ADDRESS<br>Elizabeth D. Sengstack - (same as 13e)   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of lung w. E. metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>to liver and bone</u>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>60 hrs</u><br><u>15 months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>69</u> , to <u>January</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>Jan 4</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Ralph F. Patten M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED<br>1-4-80   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RALPH F. PATTEN MD  |  |  |  |   |  | 22e. ADDRESS<br>1407 Woodside Parkway Silver Spring Md.                              |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 7, 80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.               |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Warner E. Pumphrey, Inc.   |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 9 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ralph Patten</u>   |  |  |  |
| 26. ADDRESS<br>8434 Ga. Ave., S.S. Md.   |  |  |  |   |  |  |  |   |  |  |  |



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 0 2 1 5 9

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Holly M. Sexton</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>January 4, 1980</b> |   |  | 2b. HOUR <b>5:30 AM</b>  |  |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 25 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENT</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont. Cty.</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>T.P. Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>W.H.S.H. ADVENTIST HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |  |  |  |
| 13a. STATE <b>MD.</b>   |  | 13b. COUNTY <b>mont.</b>   |   | 13c. CITY OR TOWN <b>T.P. Md.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM H. MATNEY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FRANCES ROBINSON</b>   |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>235-28-2400</b>   |   | 17. INFORMANT ADDRESS<br><b>ANNA KULKA - DAUGHTER - SAME ADDRESS</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>4912<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Emphysema</b><br>(c) <b>Chronic Bronchitis</b>                                 |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR</b><br><b>10 YRS</b><br><b>20 YRS</b>                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Manic Depressive Psychosis</b>  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> , 19 <b>79</b> , to <b>1/3</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Alfred Munzer M.D.</b> DEGREE  |  |  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/4/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfred Munzer, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>7600 Carroll Avenue Takoma Park, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>1-4-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington Medical School Wash. D.C.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Metropolitan Funeral Service</b>  |  |  |   | 24b. ADDRESS<br><b>5517 Vine Street Alexandria, Virginia</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McBrady</b>   |  |



5017 Vine Street Alexandria, Virginia  
Neurological Hospital Service  
1-4-30 George Washington Medical School, Wash. D.C.

Ann Kline, Director - State House

MA.

X

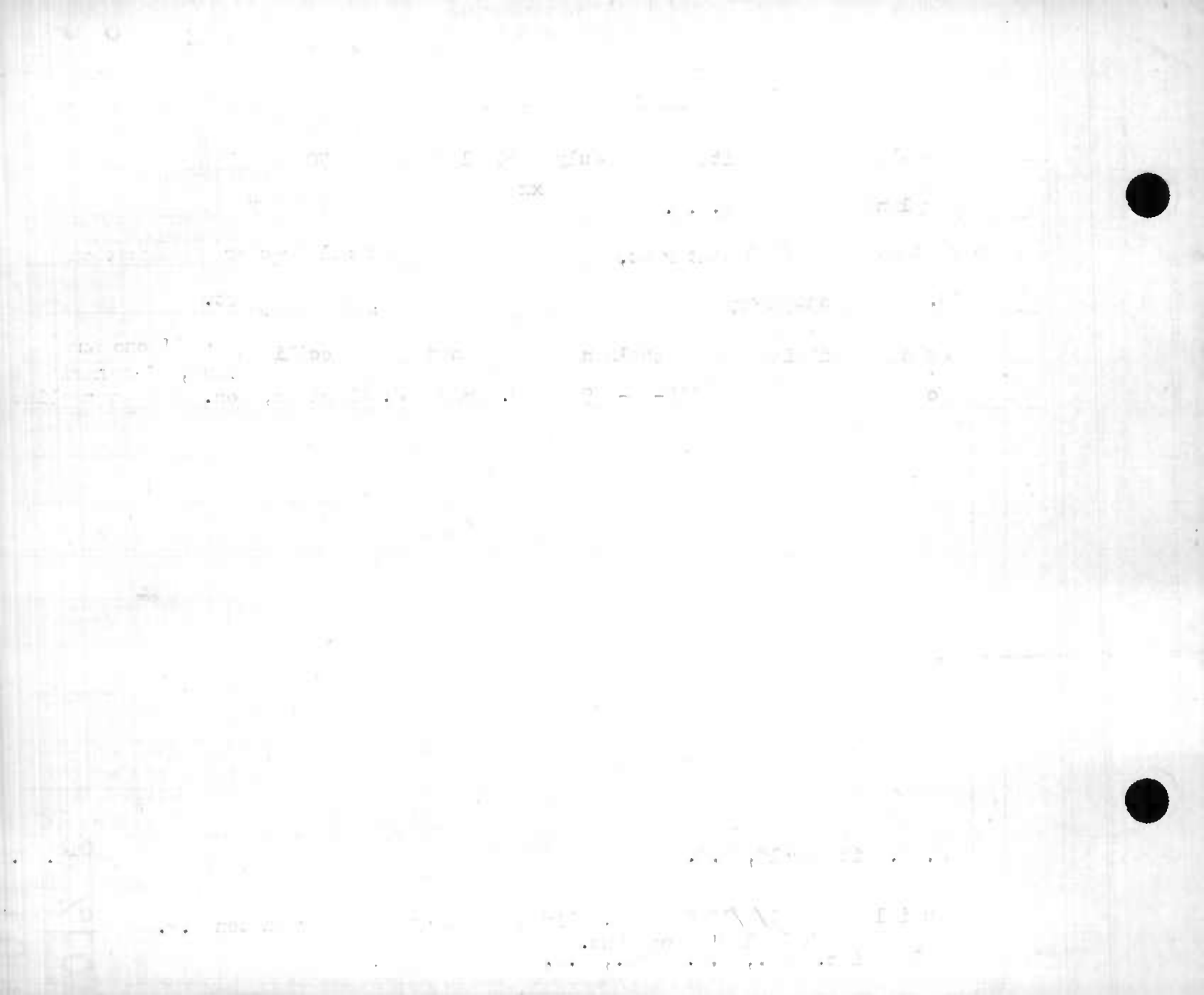


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7 0 0 2 1 6 0  |  |  |  | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MILDRED  |  | MIDDLE STOHLMAN  |  | LAST SHERIDAN  |  | 2a. DATE OF DEATH MONTH DAY YEAR JAN 30 1980   |  | 2b. HOUR 6A M   |  |
| 3. SEX Female  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR July 30 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS                                       |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.                          |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH Chevy Chase  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5416 Center st. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher |  | 12b. KIND OF BUSINESS OR INDUSTRY Education  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE Md.   |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS 5416 Center st.                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John William Stohlman  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Cecilia O'Donoghue   |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 217-46-9599   |  | 17. INFORMANT ADDRESS Dr. Andrew J. Sheridan, Son. 6356 Evangeline Lane, Alexandria Va   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Carcinomatosis</u><br>(c) <u>Ca Colon</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>6 mo<br>1 1/2 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to 1/30 19 80, that (I) (we) lost now the deceased alive on 1/28 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE J. E. Fitzgerald, M.D.  |  |  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 1/30/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. E. Fitzgerald, M.D.   |  |  |  | 22e. ADDRESS 3800 Reservoir Rd N.W., Wash. D.C.  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/2/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.                      |  |  |  |   |  |
| 24. FUNERAL DIRECTOR Joseph Lawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 02161                               |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                      |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN VIOLA SHUMAKER</b>   |  |  |  |  |  |  |  |  |  | 2b. DATE ESTIMATED <b>Jan 12, 1980</b>       |  |
| 3. SEX <b>Female</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>Jan. 4, 1920</b> 6. AGE (IN YEARS) <b>60</b> YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                           |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>Jan 12, 1980</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen Hosp.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Wife</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |  |  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>Gr. Thosburg</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>4300 Sandown Rd.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Arthur</b> MIDDLE <b>-</b> LAST <b>Saunders</b> 15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b>-</b> LAST <b>Dennison</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>579-12-0733</b> 17. INFORMANT ADDRESS <b>Milfred L. Shumaker Same as #13</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4291</b>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER DATE SIGNED <b>Jan 12, 1980</b>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b> ADDRESS <b>Silver Spring, Md.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>Jan. 15, 1980</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laytonsville Mont. Md.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md. 20760</b> 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Barbara McCreedy</b>  |  |  |  |  |  |  |  |  |  |  |  |

24

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR   |  |
| JOSEPH   |  | PAUL  |  | SIMONS   |  |   |  | 1 19 80  |  | Around 8 AM  |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 UNDER 1 YEAR<br>MONTHS DAYS                                  |  | 8 UNDER 24 HRS<br>HOURS MIN  |  |
| MALE   |  | WHITE   |  | MARCH 25, 1901   |  | 78 YRS.   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |  |  |
| WASHINGTON, D.C.   |  | U.S.A.  |  |  |  | MONTGOMERY MD.  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| CHEVY CHASE  |  | 2302 WASHINGTON AVENUE  |  |  |  | RESTAURANT OWNER  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| MARYLAND   |  | MONTGOMERY  |  | CHEVY CHASE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2302 WASHINGTON AVENUE   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| PETER SIMONS   |  |   |  | AMELIA SAROFIA   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  | ADDRESS   |  |  |  |  |  |
| NO   |  | 578-46-1732   |  | SON<br>JACK SIMONS   |  | 5844 MARBERRY ROAD<br>BETHESDA, MA. 2003                            |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>410-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hours</u><br><u>years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Emphysema</u>   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
|  |  | P.M. 19   |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
|  |  |   |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19 <u>80</u> to <u>JAN</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>JAN</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Donald A. O'Kieffe MD</u>   |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED<br><u>1/20/80</u>                             |  |  |  |
|  |  |   |  |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Donald A. O'Kieffe</u>   |  |   |  | 22e. ADDRESS<br><u>916 19th St NW Washington DC</u>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY   |  | STATE  |  |
| BURIAL   |  | 1/23/80   |  | ST. MARY'S   |  | WASHINGTON, D.C.  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>FRANCIS J. COLLINS</u>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE<br><u>Theresa Kelly</u>             |  |  |  |
| 500 UNIV. BLVD., W. SILVER SPRING MD. 20901  |  |   |  |  |  | JAN 24 1980   |  |  |  |  |  |



STATE OF MARYLAND

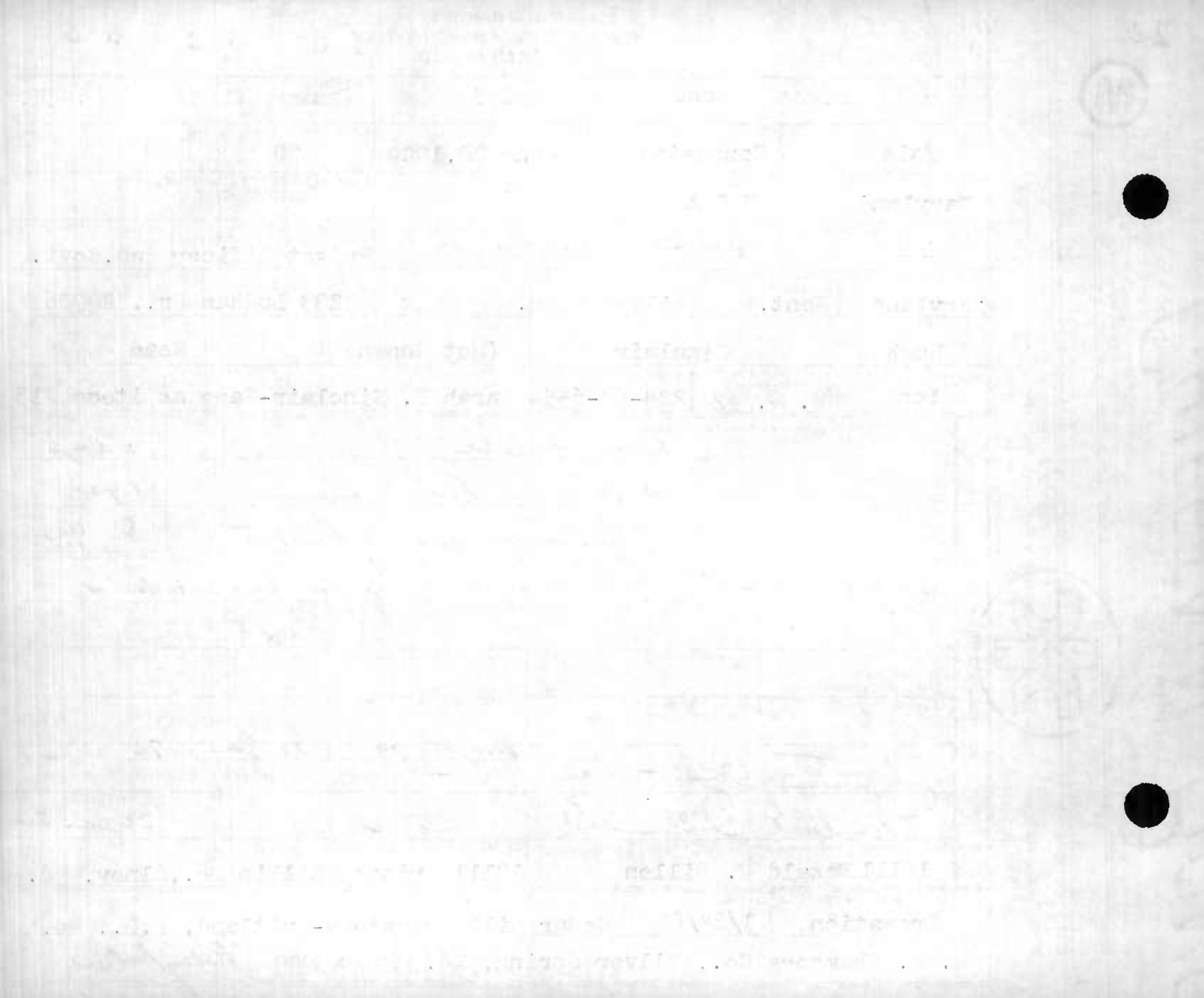
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |                           |  |  |
|--|--|---|--|--|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Francis Mead Sinclair</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>January</b> DAY <b>22</b> YEAR <b>1980</b> |  | 2b. HOUR<br><b>4:45P.</b> |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>28</b> YEAR <b>1909</b>   |                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Budget Officer</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Govt.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |                           |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Silver Sprg.</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Hugh</b> MIDDLE <b>Sinclair</b> LAST <b>Sinclair</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>(Not Known)</b> MIDDLE <b>Mead</b> LAST <b>Mead</b>   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W. W. #2</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Sarah P. Sinclair-Same as items #13</b>  |                           |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver failure</b><br>185-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Metastatic liver cancer</b><br>(c) <b>Adenocarcinoma of Prostate</b> |  |   |  |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>1 yr</b><br><b>Sev. Yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Non-function of Kidney, Pneumothorax, Urinary infection, Bone metastasis</b>  |  |   |  |  |                           |  |  |
| 19a. DATE OF OPERATION<br><b>22 Jan 80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>May 19 79</b> to <b>22 Jan 80</b> , that (I) <del>last</del> saw the deceased alive on <b>22 Jan 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death          |  |   |  |  |                           |  |  |
| 22b. SIGNATURE<br><b>Donald E. Dillon MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                           | 22c. DATE SIGNED<br><b>22 Jan 80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald E. Dillon</b>   |  |   |  | 22e. ADDRESS<br><b>18111 Prince Phillip Dr., Olney, Md.</b>  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1/24/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory-Suitland, P.G., Md.</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. Chambers Co., Silver Spring, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1980</b>  |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |                      | REG. NO. 02164  |  |
|---|--|---|--|---|--|--|--|---|----------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kuldip D. Singh</b>  |  |   |  |   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-11 1980</b> |   | 2b. HOUR <b>1458</b> |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 8 33</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>46 YRS.</b>   |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. <b>X</b>                       |                      | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1-11 1980</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>India</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>India</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD                                    |  |   |                      |   |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Holiday Inn</b>                      |                      |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |   |                      |   |  |
| 13a. STATE <b>md.</b>   |  | 13b. COUNTY <b>Montg.</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>24 W. Deer Park Dr.</b>                            |                      |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Arthur G. Singh</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Edith Mall</b>   |  |  |  |   |                      |   |  |
| 16a. WAS DECEASED EVER (YES, NO, OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>214 92 0748</b>   |  | 17. INFORMANT <b>Bela G. Singh</b>  |  |  |  | ADDRESS <b>same as 13e</b>  |                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b><br><b>411-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  |   |                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |   |                      |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                      | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |                      |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                      |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |   |                      |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |   |  | TITLE (SPECIFY) <b>Deputy</b>   |  |  |  | DATE SIGNED <b>Jan 11, 1980</b>   |                      |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |  |   |  | ADDRESS <b>Old Georgetown Rd. Bethesda, Md.</b>   |  |  |  |   |                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/14/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b> |                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b>  |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR <b>JAN 17 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Lester M. Ball</b>                          |                      |   |  |
| 1331 Rockville Pike Rockville, Maryland 20852   |  |   |  |   |  |  |  |   |                      |   |  |

[illegible]

f l m s . r o o t

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                   |   |  |   |                                   |   |  |
|---|--|-------------------|---|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                   | 2a. DATE KNOWN OF DEATH   |  |   | 2b. HOUR                          |   |  |
| Brenda Joyce Skinner  |  |                   | 1 25 19 80  |  |   | M                                 |   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD          | 2d. HOUR  |  |
| Female  | White  | JAN. 30 43        | 36 YRS.   |  |   | 1 25 19 80                        | 12:18 P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |   |  |
| PA.   | U.S.A.   |                   |   |  | Montgomery County, MD.  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Silver Spring   | 8750 Georgia Avenue  |                   |   | SCHOOL TEACHER   |   | RETIRED                           |   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS               |   |  |
| MD.   | MONT. CO.  |                   |   |  |   | 8750 GEORGIA AVE.                 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |                                   |   |  |
| MARTIN  |  |                   | ZANOTTI   |  |   | UNKNOWN                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |                   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |                                   |   |  |
| No  |  |                   | 177-38-9863   |  | DOUGLAS E. SKINNER 3826 GAWAYNE TERR.   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9889 IMMEDIATE CAUSE (a) Cerebral edema with midbrain compression<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                   |   |  |   |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                   |   |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                   |   |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |                   |   |  |   |                                   |   |  |
| ACTUAL SIGNATURE  |  |                   | TITLE (SPECIFY)   |  |   |                                   | DATE SIGNED   |  |
| Thomas D. Smith, M.D.   |  |                   | Deputy Chief  |  |   |                                   | 1/26/80   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                   | ADDRESS   |  |   |                                   |   |  |
| Thomas D. Smith, M.D.   |  |                   | 111 Penn St. Balto., MD.  |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)   |  |                   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY  |  |
| BURIAL  |  |                   | 1-28-80   |  | GREENWOOD MEM. PARK   |                                   | WEST MONTGOMERY PA.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |                   | ADDRESS   |  | DATE REC'D. BY REGISTRAR  |                                   | REGISTRAR'S SIGNATURE   |  |
| THOMAS J. SKARDA  |  |                   | 2829 HUDSON ST.   |  | JAN 29 1980   |                                   | Luttrell McCreedy   |  |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 002166  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Christina Selvan Smith</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>January 19, 1980</b>   |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>October 29, 1974</b>  |  | 2b. HOUR <b>10:40 AM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>(Unknown)</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>5</b> YRS MONTHS DAYS HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>  |  |
| 13a. STATE <b>New York</b>   |  | 13b. COUNTY <b>Suffolk</b>   |  | 13c. CITY OR TOWN <b>Central Islip</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Arnold - Smith</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Reyhan - (Unknown)</b>   |  | 16. PALM STREET ADDRESS <b>16 Palm Street</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT ADDRESS (same as above) <b>Mrs. Reyhan Smith, mother</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>   |  |  |  | <b>30 seconds</b>  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Burkitt's Lymphoma</b>   |  |  |  | <b>13 months</b>   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 3, 1980</b> to <b>January 19, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 19, 1980</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Robert T. McGuire</b> DEGREE _____   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/20/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT T. MCGUIRE</b>   |  |  |  | 22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Jan/23/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bayshore, New York</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home - Riverdale, Maryland</b> ADDRESS _____   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>  |  |

(Значит)



*[Handwritten signature]*

1948

Секретариат - 1000



0100 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

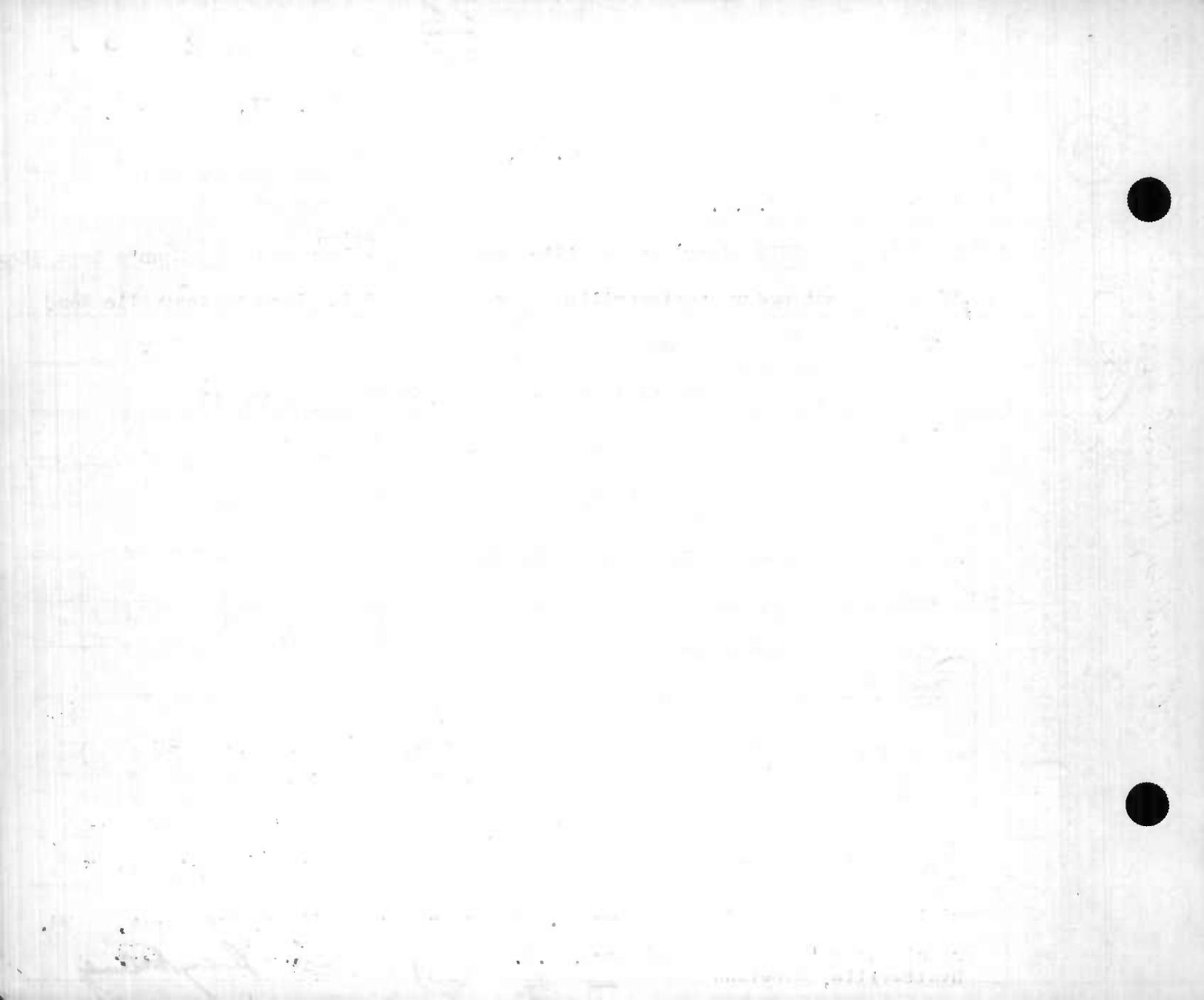
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 1 6 7  
REG. NO.

|   |  |  |  |   |   |  |  |   |   |  |
|---|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRENE (NMN) SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 11, 1980</b>            |   |   | 2b. HOUR<br><b>6<sup>00</sup> A.M.</b>   |  |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 12, 1887</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>LAYTONSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6512 Olney Laytonsville Road</b> |  |   |   | 12. USUAL OCCUPATION<br>(MOST OF WORKING LIFE)<br><b>Retired Saleswoman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Kann's Dept Store</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. CITY OR TOWN<br><b>Montgomery</b>                                 |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>6512 Olney Laytonsville Road</b>                 |   |   |  |
| 14. FATHER'S NAME<br><b>SAMUEL</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>ANN</b>                                 |   |   | 16. ADDRESS<br><b>MUNSON</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>579 12 4829</b>                         |   | 17. INFORMANT<br><b>ANNA MAE POINTER</b>  |  |  |   | 17. ADDRESS<br><b>Same as #13</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410- Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                       |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)   |  |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 19 80</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 5, 1980</b> to <b>Jan 11, 1980</b> , that (1) (we) last saw the deceased alive on <b>Jan 5, 1980</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (do) (do not) view the body after death. |  |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Lewis Kellert, MD</b>  |  |  | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/11/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis Kellert, MD</b>   |  |  | 22e. ADDRESS<br><b>1811 Prince Phillips Dr. Annapolis, Md. 20732</b>   |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/14/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Manor Ch. of the Brethren</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Tilghamnton Wash. Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. ...</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Hyattsville, Maryland</b>  |  |  |  |   |   |  |  |   |   |  |



CLEARED BY MEDICAL EXAMINER - DR. JOHN ROGER  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| WILLIAM  |  | SOBER  |  | 1/15/80  |  | 7:16 P.M.   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR                           |  |
| MALE   |  | WHITE  |  | OCTOBER 14, 1912   |  | 67 YRS  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| WASHINGTON, D. C.  |  | U. S. A.   |  |  |  | MONTGOMERY  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| SILVER SPRING  |  | HOLY CROSS HOSPITAL  |  | POSTAL   |  | U.S. GOV'T.   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| MARYLAND   |  | MONTGOMERY   |  | SILVER SPRING  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 11609 LOCKWOOD DRIVE, APT. 101               |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                        |  |
| ABRAHAM  |  | EIGE   |  | YES  |  | 577-60-5852   |  | YETTA S. SOBER, same as #13                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____                           |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 4/148  |  | Congestive heart failure   |  | 2 hours  |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
|  |  | Ischemic heart disease   |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
|  |  |  |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |
| previous myocardial infarct  |  | previous myocardial infarct  |  | previous myocardial infarct  |  | previous myocardial infarct   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED  |  |  |  |
|  |  | P.M. 19  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |
| 21f. INJURY OCCURRED   |  | 21g. PLACE OF INJURY   |  | 21h. LOCATION  |  | 21i. CITY OR TOWN   |  | COUNTY STATE                                 |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21j. PLACE OF INJURY   |  | 21k. LOCATION  |  | 21l. CITY OR TOWN   |  | COUNTY STATE                                 |  |
|  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from saw the deceased alive on above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (d) <input type="checkbox"/> view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS                                 |  |
| 1/28 79 Aug  |  | Dr. John M. Evans MD   |  | 1/16/80  |  | DR. JOHN M. EVANS, M. D.  |  | 5480 WISCONSIN AVENUE, CHEVY CHASE, MARYLAND |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. CITY OR TOWN                            |  |
| BURIAL   |  | 1/17/1980  |  | MOUNT LEBANON CEMETERY   |  | ADELPHI   |  | PR, GEORGES MD.                              |  |
| 24. FUNERAL DIRECTOR   |  | 24b. DATE RECORDED BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE   |  | 24d. REGISTRAR'S SIGNATURE  |  |  |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |  | JAN 21 1980  |  | [Signature]  |  | [Signature]   |  |  |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D.C.   |  |  |  |  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 80 02169  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 2b. HOUR MIN   |  |   |  |
| Othmar C. Solnitzky  |  |  |  | Jan 14-80 10 <sup>25</sup> P.M.  |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN   |  |
| Male   |  | White  |  | Oct. 22, 1897  |  | 82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Romania  |  | U.S.A.   |  |  |  | Montgomery County, MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Chevy Chase  |  | Bethesda Ret. & Nursing Center   |  | Medical Doctor   |  | Medicine  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Maryland   |  | Montgomery   |  | Bethesda   |  | 13e. STREET ADDRESS   |  |
|  |  |  |  |  |  | 10518 Weymouth Drive  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |
| Edward - Solnitzky   |  | Marie - Hanosek  |  | No   |  |   |  |
|  |  |  |  | 16b. SOCIAL SECURITY NO. 578-44-1419   |  |   |  |
|  |  |  |  | 17. INFORMANT ADDRESS Sarah Solnitzky - Address same as #13.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Generalized arteriosclerosis  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |  |  |   | Years  |
| (b) Chronic Brain Syndrome   |  |  |  |  |  |   | 5 + Yrs                                      |
| (c)  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 22 - 29 1975, to Jan 14 1980, that (1) (we) last saw the deceased alive on Dec 22 - 29 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE George I. Mishtowt, M.D.  |  |  |  | DEGREE   |  | 22c. DATE SIGNED 1-14-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George I. Mishtowt, M.D.   |  |  |  | 22e. ADDRESS 5454 Wisconsin Avenue-Chevy Chase, Maryland   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal  |  | 23b. DATE Jan. 15, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY Georgetown Med. School  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.  |  |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home - Silver Spring, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 21 1980  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

U.S. DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

Washington, D.C.  
January 1, 1901  
The Honorable  
The President  
The Vice President  
The Speaker of the House  
The Chief Justice of the Supreme Court  
The Justices of the Supreme Court  
The Members of the Cabinet  
The Members of the Senate  
The Members of the House  
The Members of the Judiciary  
The Members of the Executive Branch  
The Members of the Legislative Branch  
The Members of the Judicial Branch

Dear Sirs:  
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter of the proposed amendment to the Constitution of the United States, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
J. Edgar Hoover  
Special Agent in Charge

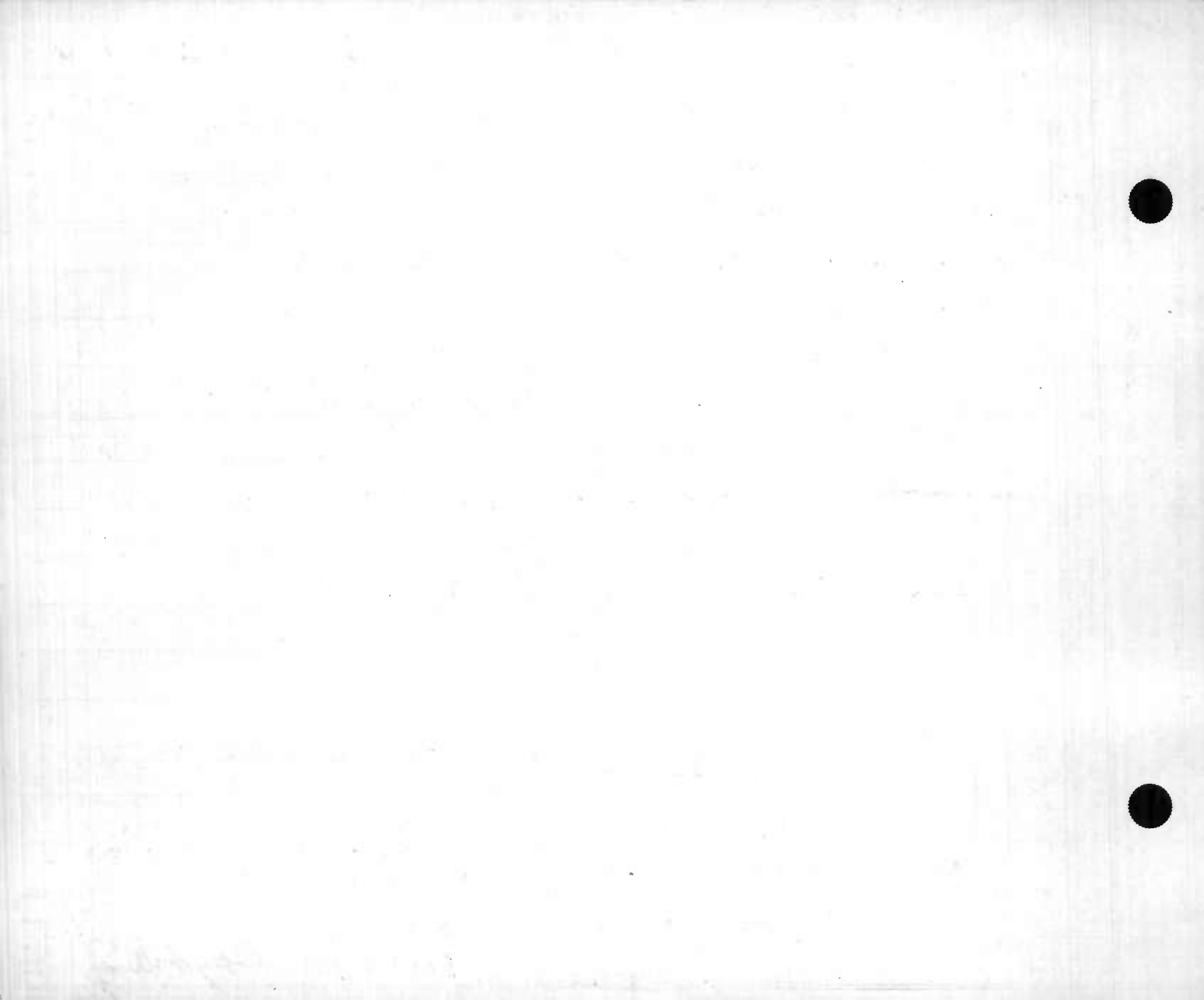
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                                       |   |  |   |   | REG. NO. 80 02170   |  |
|---|--|--|--|--|---------------------------------------|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANNA P STAMOS</b> |  |                                       |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-23-80</b>   |   |   | 2b. HOUR<br><b>1:45 A.M.</b>  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 20, 1897</b>   |                                       | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>82</b>                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>   |   | IF UNDER 24 HRS. HOURS MIN.<br><b>15 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                      |  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  |                                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>11205 Rock Road</b> |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Philip Philip</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maria (unknown)</b>  |                                       |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>105-12-1513D</b>   |  | 17 INFORMANT<br><b>Nicholas Stamos</b>   |                                       | ADDRESS<br><b>11126 Schuylkill Rd. Rockville, Md.</b>                             |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DIGITALIS INTOXICATION</b><br><b>558-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DEHYDRATION AND ELECTROLYTE IMBALANCE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE GASTROENTERITIS</b>            |  |  |  |  |                                       |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>4 DAYS</b><br><b>8 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Anterior lentis Heart Disease; chronic mening; Renal calculus; Anemia</b>  |  |  |  |  |                                       |   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>— 0 —</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>— 0 —</b>   |  |  |                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. NA 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>NA</b>  |                                       |   |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>— 0 —</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>— 0 —</b>   |                                       |   |  |   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JUNE 10, 1974</b> , to <b>JANUARY 23, 1980</b> , that (1) (we) last saw the deceased alive on <b>JAN. 22, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |                                       |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>John B. Nason, MD</b>  |  |  |  | DEGREE<br><b>MD</b>  |                                       |   |  | 22c. DATE SIGNED<br><b>1-23-80</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN B. NASON, MD.</b>  |  |  |  | 22e. ADDRESS<br><b>800 BENTLEY DR., SUITE 105A SILVER SPRING, MD. 20910</b>  |                                       |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 25, 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood Prince George, Md.</b>    |  |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hines/Rinaldi Funeral Home</b>  |  |  |  | 24b. ADDRESS<br><b>11800 New Hampshire Ave. Silver Spring, Md.</b>   |                                       |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>History K. Bredy</b>   |  |



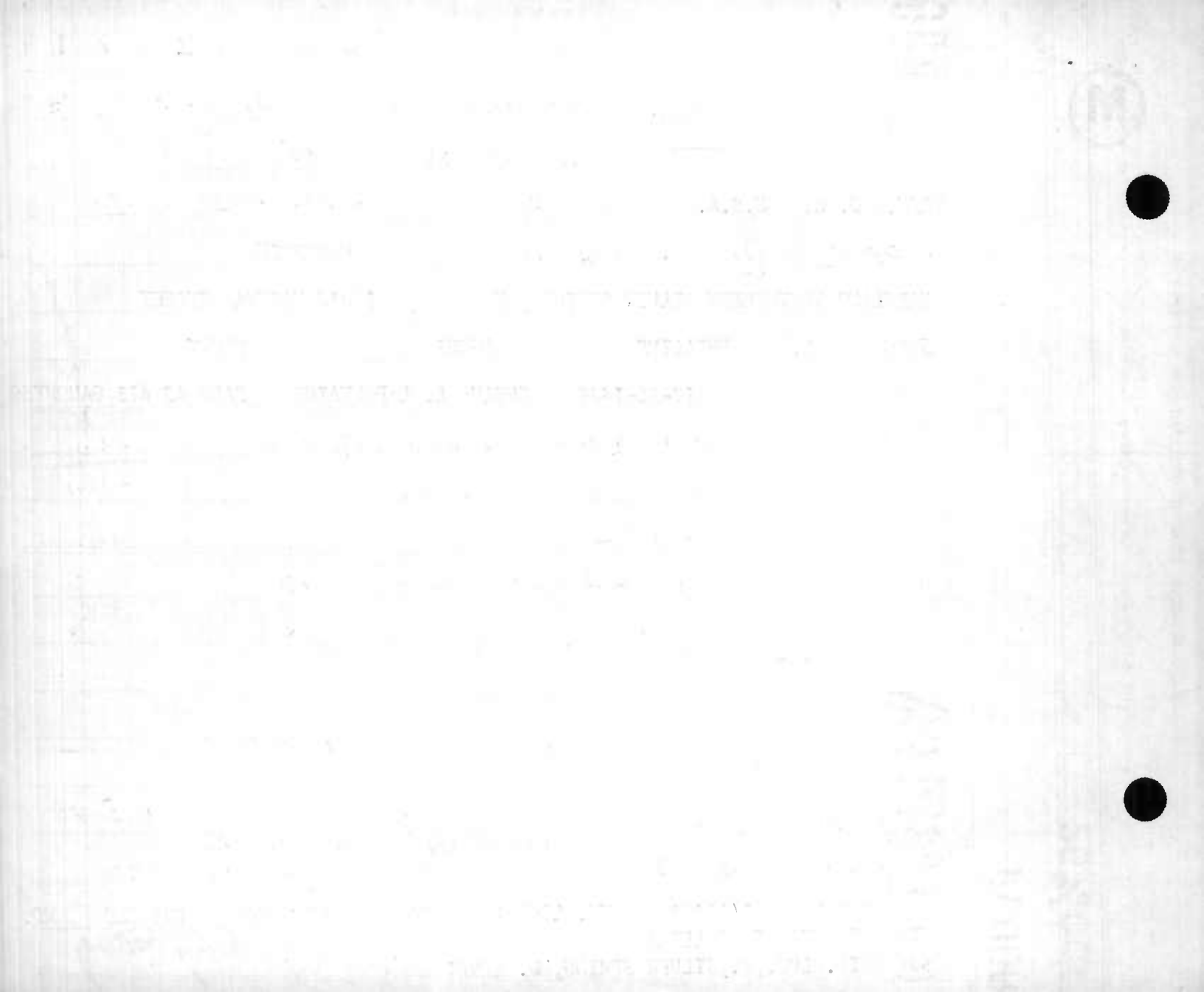


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 1 7 1  
REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |   |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Josephine Agnes Stanford</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>01</i> DAY <i>12</i> YEAR <i>80</i> |   |  | 2b. HOUR<br><i>6 16 P.M.</i>   |  |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>WHITE</i>   |   | 5. DATE OF BIRTH<br>MONTH <i>11</i> DAY <i>15</i> YEAR <i>84</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>95</i> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>WASH., D. C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>MONTGOMERY</i> 13c. CITY OR TOWN <i>SILVER SPRING</i>   |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>10014 MARKHAM STREET</i>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <i>JOHN</i> MIDDLE <i>R.</i> LAST <i>PHILLIPS</i>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>AGNES</i> MIDDLE <i>EBERT</i> LAST <i></i>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>217-32-1469</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>EVELYN L. LaFONTEINE SAME AS #13 DAUGHTER</i>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Inferior Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Acute pulmonary Edema</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Acute Renal Failure</i>   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>2 days</i><br><i>2 days</i>                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>CHF, Aortic Stenosis, Chronic Renal Failure, ASCVD</i>  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>None</i>   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><i>None</i>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) <del>this hospital</del> attended the deceased from <i>7-12-79</i> , 19____, to <i>7-12-80</i> , 19____, that (1) <del>was</del> last saw the deceased alive on <i>7-12-80</i> , 19____, and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) <del>not</del> view the body after death. |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>G B Patrick III MD</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><i>1-12-80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G B Patrick III MD</i>   |  |   |   | 22e. ADDRESS<br><i>9221 Colesville Rd Silver Spring, Md 20910</i>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>1/16/80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>FT. LINCOLN CEMETERY</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BRENTWOOD PRI GEO MD.</i>           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>  |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><i>JAN 16 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barney Kennedy</i>                                  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8002172  |  |  |   |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RAE STARR   |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>JANUARY 19, 1980                   |  |  | 2b HOUR<br>1:35P M  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>February 5, 1907   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Takoma Park  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |  |  |   |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Silver Spring  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>1220 East West Hwy., #219   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Abraham Gordon   |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Esther Nos Ascertainable |  |  |   |  |
| 16a WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>173-12-7527  |  | 17 INFORMANT<br>Albert Starr   |   |  | ADDRESS<br>Same as No. 13  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 min<br>10 yrs. |  |   |  |  |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |  |  |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (1) (this hospital) attended the deceased from <u>June</u> , 19 <u>79</u> , to <u>1-19</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>79</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |  |   |  |
| 22b SIGNATURE<br><u>Bernard H. Ostrow MD</u>   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>1-20-80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD H. OSTROW  |  |   | 22e ADDRESS<br>5225 Pooks Hill Rd BETHESDA MD.                     |  |   |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b DATE<br>1/22/1980  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mount Sharon Cemetery            |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Springfield Delaware PA. |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Donald M. Stein Hebrew Memorial F.H.   |  |   |  |  |   | 25a DATE REC'D BY REGISTRAR (USE REGISTRAR'S SIGNATURE)<br>JAN 25 1980 <u>Henry McCreedy</u>   |  |   |  |
| 232 Carroll St., N. W. Washington, D. C.   |  |   |  |  |   |  |  |   |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 0 0 2 1 7 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                              |  |   |  |   |  |
|--|--|---|---|---|------------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Victoria E. Stearns   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 15, 1980                 |   |                              | 2b. HOUR<br>1 P.M.   |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 11 1911  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Potomac   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10050 Councilman Dr. |   |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. GOVT.  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |   | 13c. COUNTY<br>Montgomery   |   | 13d. CITY OR TOWN<br>Potomac |  | 13e. STREET ADDRESS<br>10050 Councilman Dr. |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR STEARNS   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NETTIE ELDRIDGE        |   |                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |   |  | 16b. SOCIAL SECURITY NO.<br>023-03-2826 |  |
| 17. INFORMANT<br>ADDRESS<br>WASHINGTON, D.   |  |   | 17. INFORMANT<br>ADDRESS<br>ROSS O'DONOGHUE 1200 17th ST., N.W. 20036   |   |                              |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis - Terminal</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Adenocarcinoma - Colon.</u><br>JUNE 15, 1979<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Since</u> |  |   |   |   |                              |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Since</u>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>   |  |   |   |   |                              |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>June 15, 1979</u>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Cancer Colon</u> |   |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1979</u> to <u>Jan 15, 1980</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.  |  |   |   |   |                              |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Blair H. S. P.A.</u>  |  |   | DEGREE<br><u>M.D., P.A.</u>   |   |                              | 22c. DATE SIGNED<br><u>1/15/80</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 22d. PHYSICIAN'S ADDRESS<br><u>10,000 Falls Road</u>   |  |   | 22e. ADDRESS<br><u>10000 Falls Road Potomac, Md.</u>                    |   |                              |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  |   | 23b. NAME OF CEMETERY OR CREMATORY<br><u>METROPOLITAN CREMATORY</u>     |   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ALEXANDRIA FAIRFAX VIRGINIA</u>                       |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A   |  |   | ADDRESS<br>ROCKVILLE MD.  |   |                              | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 21 1980</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCready</u>  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



IN SENATE,  
January 10, 1912.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 10, 1911.

ALBANY:  
J.B. LIPPINCOTT & CO.,  
PRINTERS,  
1912.

THE LAND OFFICE OF THE STATE OF NEW YORK  
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT  
OF THE REPORT OF THE COMMISSIONERS OF THE  
LAND OFFICE, IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE MAY 10, 1911,  
AND TO TRANSMIT THE SAME TO THE SENATE  
FOR ITS CONSIDERATION.

ATTEST:  
JANUARY 10, 1912.  
J. B. LIPPINCOTT & CO.,  
PRINTERS.



1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02174

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Susan A. STEIN Silverstein

2a. DATE KNOWN OF DEATH MONTH DAY YEAR  
1 27 19 80

2b. HOUR M  
6:30 A M

3. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR  
9 26 36

6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN  
43 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Ohio

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Montgomery County, MD.

10. CITY OR TOWN OF DEATH  
Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
6012 Chatsworth Lane

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Md.

13b. COUNTY Mont

13c. CITY OR TOWN Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS  
6012 Chatsworth Lane

14. FATHER'S NAME FIRST MIDDLE LAST  
Morris S. Silver

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Mabel Passamanek

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
No

16b. SOCIAL SECURITY NO.  
289-32-1872

17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: Acute doxepin & trichloroethanol intoxication  
9803 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
2:00 P.M. 1/27/80

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
ingested drugs

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
home

21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
6012 Chatsworth Lane, Bethesda, Mont., Md.

22a. I certify that I took charge of the body described above, held on death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE *Thomas D. Smith* TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER DATE SIGNED 1/27/80

EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal

23b. DATE 1/28/80

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS  
Anatomy Board Balto., Md.

25a. DATE REC'D. BY REGISTRAR FEB 04 1980

25b. REGISTRAR'S SIGNATURE *Henry McCreedy*

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Albion

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 0 0 2 1 7 5<br>REG. NO.  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Adores Sean Sterling</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-27-80</b>  |  | 2b. HOUR<br><b>4:13 P</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4-19-31</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sakoma Park, Md.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C&amp;P Telephone Co</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Laurel</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8008 Crest Road</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Miles C Clifford</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Anna Elizabeth Sago</b>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>183-24-4444</b>  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Max Sterling Jr 8008 Crest Road<br/>Laurel, Md., 20810</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Primary Pulmonary Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>DAY</b><br><b>Years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Crown artery disease</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A-M- MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27/80</b> 19 <b>80</b> to <b>1/27</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/27</b> 19 <b>80</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                          |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Jamuel J. Scott, Jr.</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/27/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMUEL J. SCOTT JR</b>   |  | 22e. ADDRESS<br><b>5632 SHIELDS DRIVE, BETHESDA, MD.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>  |  | 23b. DATE<br><b>1/28/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Grove Cem</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mount Morris, Penna.</b>  |  | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><b>FEB 1 1980</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Murphy-Falls Church</b>  |  | 24b. ADDRESS<br><b>1102 W. Broad St.<br/>Falls Church, Va.</b>  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 8002176  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN Benjamin STERLING</b>  |  |   |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 26, 1980</b>   |  | 7b. HOUR<br><b>9 H. M.</b>                                    |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>W. hite</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 6, 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9210 Manchester Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9210 MANCHESTER RD.</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lynwood J. Sterling</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth Camilier</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-9147</b>  |  | 17. INFORMANT<br><b>wife Nell L. Sterling</b>  |  | ADDRESS<br><b>same as 13e</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Conc.</b><br><b>1719</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Lipo sac conc.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 1/2 yrs.</b>       |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>not</b> 19 <b>77</b> to <b>1126</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>115</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>S. S. G. I. A. M. D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/26/80</b>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDGAR H. LEVIA</b>   |  |   |  | 22e. ADDRESS<br><b>8630 FENTON ST.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 29, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Aloysius Ch. Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Leonardtown St. Mary's Md.</b>                 |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Francis J. Collins</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1980</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |   |  |
| 500 University Blvd., W. Silver Spring, Md.  |  |   |  |   |  |  |  |  |  |   |  |

BP

RECEIVED  
JAN 10 1962

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]  
[illegible text follows]

[illegible text follows]

Very truly yours,  
[illegible signature]  
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |   |  |  |  |  |  | REG. NO. 0 2 1 7 7   |  |
|--|--|---------------------|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                     |  |   |  |  |  |  |  |  |  |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Louise A. Stewart</b>   |  |                     |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br><b>1-30-80 2:42P</b>                   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug 28 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>84 YRS.</b>                      |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>1-30-80 2:42P</b>  |  | 2d. HOUR<br><b>M</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Tk. Bk. Washington</b>   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Adventist Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>House</b>                                |  |
| 13a. STATE<br><b>Maryland</b>  |  |                     |  | 13b. CITY OR TOWN<br><b>Pr. Geo. Mitchellville</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>13505 Annapolis Rd.</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Francis Poula</b>  |  |                     |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Earnestine Rochlitz</b>                     |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>no</b>  |  |                     |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>n/a</b>  |  | 17. INFORMANT ADDRESS<br><b>Clement Tydings Same as # 13</b>                                 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>410- IMMEDIATE CAUSE (a) Acute Myocardial Dis.</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>(b) Chronic Myocardial Dis.</b><br><b>(c)</b>   |  |                     |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |                     |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John S. Rodgers</b>   |  |                     |  |   |  | TITLE (SPECIFY)<br><b>Dep.</b>   |  |  | DATE SIGNED<br><b>Jan 30 1980</b>                    |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rodgers</b>  |  |                     |  |   |  | ADDRESS<br><b>Silver Spring, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                     |  | 23b. DATE<br><b>2 FEB 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>                           |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood, Md.</b>                 |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert G. Beall</b>  |  |                     |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert G. Beall</b> |  |  |



1-30-80 2:42

1-30-80 2:42

None.

Washington Adventist Hospital

1-30-80 2:42

1-30-80 2:42

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 002178   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 20. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Malcolm W. STIFF   |  |   |  | January 2 1980  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 26 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Medical Service Rep.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pharmacy   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br>Maryland Montgomery Chevy Chase   |  |   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ballard Otis Stiff  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Lee Woodyard   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>125 10 9494   |  | 17. INFORMANT ADDRESS<br>Columbia, Md.<br>Ronald Stiff 10722 Faulkner Ridge Circle  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u><br>185-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1 19 80, to Jan. 2 19 80, that (I) (we) lost saw the deceased alive on Jan. 2 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Chris K. Finton, LT, MC  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>Jan. 3 1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Chris K. Finton, M. D.  |  |   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>I-4-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Jos. Gawler Sons  |  |   |  | ADDRESS<br>5130 Wisc. Ave. N.W.<br>Washington, D.C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1980   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

14-17

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8002179  |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Austin Orval Story  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 1, 1980   |  |   |  | 2b. HOUR<br>11:10p   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 18, 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS   |  | 7. IF UNDER 1 YEAR (MONTHS) DAYS<br>IF UNDER 24 HRS (HOURS) MIN                      |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center (NIH) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANAGER                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BOWLING LANES                                   |  |  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>2611 Urbana Drive 20906                                       |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY STORY   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>GRACE PATTEN  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>WW II 171-16-4281   |  | 17. INFORMANT ADDRESS (same as above)<br>Mrs. Esther Story (wife)                               |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypovolemic Shock<br>DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse Histiocytic lymphoma<br>DUE TO, OR AS A CONSEQUENCE OF (c) Streptococcal Sepsis<br>2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 w m<br>3 months<br>2 w m                         |  |   |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 11, 1979, to Jan. 1, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 1, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Byron D. McChes  |  |   |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>1/2/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Byron D. McChes   |  |   |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md, 20205   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>1/5/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEMETERY                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SUITLAND PRI GEO MD                       |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1980   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Rita Helms   |  |  |  |



ATTACHMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |   |
|---|--|--|--|---|---|--|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8002180   |  |   |   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HATTIE E. STOWE</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 21, 1980</b>  |  |  | 2b. HOUR<br><b>A 11:14</b>   |   |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 5 1901</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Sandy Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Friends Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Teaching</b>   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |  |  |  |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Sandy Spring</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>17320 Quaker Lane</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Philip Stowe</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Noe</b> |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212321326</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Patient record</b>   |   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic atrial fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>2 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Scleroderma</b>   |  |  |  |   |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |   |
| 22a. I certify that (I, this hospital) attended the deceased from <b>11/20</b> , 19 <b>80</b> , to <b>1/21</b> , 19 <b>80</b> , that (I/we) last saw the deceased alive on <b>1/20</b> , 19 <b>80</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |  |  |   |   |  |  |  |   |
| 22b. SIGNATURE<br><b>John G. Lodmell MD</b>   |  |  |  |   |   | DEGREE   |  | 22c. DATE SIGNED<br><b>1/21/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John G. Lodmell MD</b>  |  |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22e. ADDRESS<br><b>18111 Prince Georges Dr. - Olney Md 20832</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>1/21/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |  |  | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |   |

10-10-10

NOTED  
10-10-10

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
Yours truly,  
J. H. [Signature]





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002181  
REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH M. STURGESS |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1 24 80 |   |  | 2b. HOUR<br>8:38 AM   |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 18 15   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA MD                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SILVERBANK HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                    |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland           |   | 13c. CITY OR TOWN<br>Rockville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>1232 Clagett Drive                                    |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph G. McDowell   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Marsden  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---   |   | 17. INFORMANT<br>ADDRESS<br>Charles H. Jr. same as 13e  |  |   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u>           |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 min</u>  |  |
| 436-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cerebral vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>generalized arteriosclerosis</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><u>diabetic mellitus</u> |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1924</u> to <u>24 JAN 1980</u> , that (I) (we) last<br>saw the deceased alive on <u>24 JAN 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) did (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>1/25/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN M. WYNNER MD</u>   |  | 22e. ADDRESS<br><u>7901 Duffell Ave Bethesda, Md 20814</u>  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/29/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Northwood Cemetery   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Southampton, Pennsylvania   |  | 24. FUNERAL DIRECTOR<br>NAME Tyson Wheeler Funeral Home, Inc.<br>ADDRESS 1331 Rockville Pike Rockville, Maryland  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 80002182                                       |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Andrea</b>  |  | FIRST<br><b>B.</b>  |  | MIDDLE<br><b>S.</b>   |  | LAST<br><b>Swenson</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-29-80</b>  |  | 2b. HOUR<br><b>11:50 A.M.</b>                           |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 11 1886</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |  | 8. UNDER 24 HRS<br>HOURS MIN.<br><b>50</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sweden</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Health Care Center</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>10211 Capital View Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>216 16 2280</b>  |  | 17. INFORMANT ADDRESS<br><b>C. Marion Hale 9320 Wescott Pl. Rockville, Md</b>        |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary heart failure</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cardio-vascular disease</b><br>(c) <b>Myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6-8 months</b><br><b>10-20 years</b><br><b>30-40 years</b> |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> 19 <b>80</b> to <b>Jan 29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Katharine A. Chapman, M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Jan. 29, 1980</b>                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Katharine A. Chapman</b>   |  |   |  | 22e. ADDRESS<br><b>4305 Colchester Dr. Kensington, Md. 20795</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/31/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Mo. Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tyson Wheeler Funeral Home, Inc.</b><br>ADDRESS<br><b>1331 Rockville Pike Rockville, Maryland 20852</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>EB 1 1980</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

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Figure 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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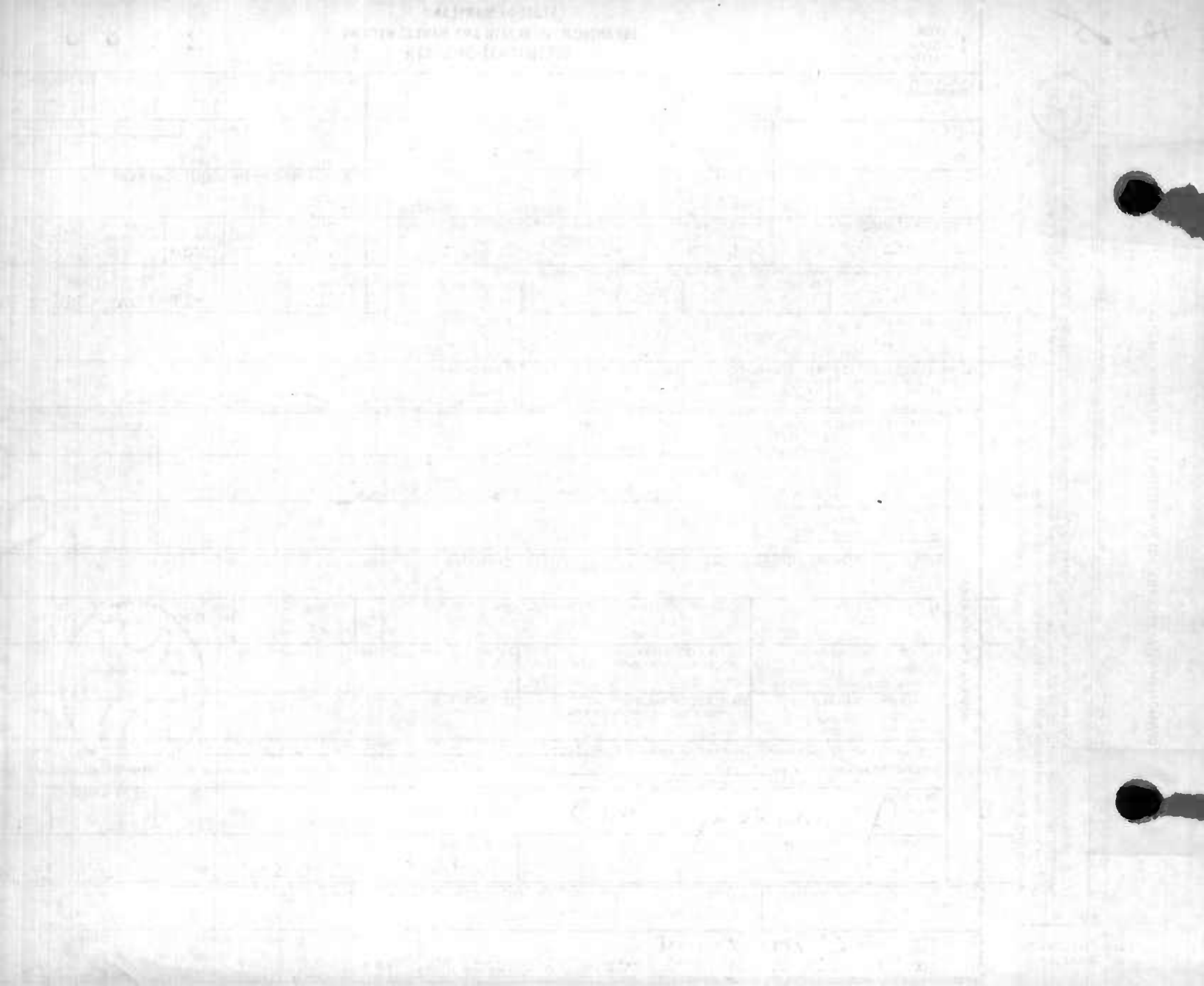
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas E. TAGER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 11 1980                              |  | 2b. HOUR<br>1:30 PM  |
| 3 SEX<br>Male   | 4 RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 16 1919  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                              |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Air Force |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Virginia   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Arlington   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herman Tager  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marcella Anderson                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1940-68  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Mary F. Tager See item 13                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>oral cell carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I/this hospital) attended the deceased from <u>Jan. 8</u> , 19 <u>80</u> , to <u>Jan. 11</u> , 19 <u>80</u> , that (I/(we) lost saw the deceased alive on <u>Jan.</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I/(we) did) (did not) view the body after death.               |  |   |   |  |  |
| 22b. SIGNATURE<br><u>T. J. Spurling</u> MD  |  | DEGREE  |   | 22c. DATE SIGNED<br>Jan. 11 1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. J. SPURLING, M.D.   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda Md  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1-16-80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va.  |
| 24. FUNERAL DIRECTOR<br>NAME <u>C. M. Fraul</u> ADDRESS<br>Murphy Arlington Funeral Home, Arlington, Va.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert...</u>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |  |
|---|--|---|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 80 REG. NO. 02184   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Albert R. Taylor   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 21 1980          |   |  | 2b. HOUR<br>2:30 PM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 10, 1911  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Master Plumber   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plumbing   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Montgomery   |  | 13c. CITY OR TOWN<br>Silver Spring  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9304 Long Branch Parkway   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Major Claude Taylor  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Flora Sharp |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>577-09-4854   |  | 17. INFORMANT ADDRESS<br>Melvina B. Taylor (wife), same as #13  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary heart disease</u>   |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>31 hrs.<br>?  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/20/80</u> 19 <u>80</u> , to <u>1/21/80</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>1/21/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Bernard J. Walsh M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br>1/29/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD J. WALSH   |  |   |  | 22e. ADDRESS<br>1800 Egl. St. N.Y. - D.C.   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>01-25-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland, P.G., Maryland               |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi Funeral Home   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 04 1980                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barney McBrady</u>   |  |
| 11800 New Hampshire Ave., Silver Spring, Md.  |  |   |  |   |   |   |  |   |  |



FEB 01 1980

*Handwritten signature*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                  |   |  |   |  |                                     |  |                                |  |          |  |
|--|--|--|------------------|---|--|---|--|-------------------------------------|--|--------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  | 80002185   |                  | REG. NO.  |  |   |  |                                     |  |                                |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2. DATE OF DEATH |   |  | MONTH   |  | DAY                                 |  | YEAR                           |  | 2b. HOUR |  |
| ELIZABETH NMI TEMEL  |  |  | 1                |   |  | 3   |  | 80                                  |  | 6:30A                          |  | M        |  |
| 3 SEX  |  | 4 RACE   |                  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7a. IF UNDER 1 YEAR                 |  | 7b. IF UNDER 24 HRS            |  |          |  |
| Female   |  | Caucasian  |                  | Jan 15, 1898  |  | 81 YRS.   |  | MONTHS                              |  | DAYS                           |  | HOURS    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                     |  |                                |  |          |  |
| Hungary  |  | U.S.A.   |                  |   |  | MONTGOMERY County MD.   |  |                                     |  |                                |  |          |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                     |  |                                |  |          |  |
| BETHESDA   |  | SUBURBAN Hospital  |                  | Homemaker   |  | Home  |  |                                     |  |                                |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?            |  | 13e. STREET ADDRESS            |  |          |  |
| Maryland   |  | Montgomery   |                  | Bethesda  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 8200 Wisconsin Avenue #716          |  |                                |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT                        |  | ADDRESS                        |  |          |  |
| Sandor   |  | Elizabeth  |                  | no  |  | 126-22-9132   |  | Seniye Temel, Same as #13           |  |                                |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):                           |  | 410- asystole  |                  | DUE TO, OR AS A CONSEQUENCE OF (b):   |  | acute myocardial infarction   |  | DUE TO, OR AS A CONSEQUENCE OF (c): |  | arteriosclerotic heart disease |  | 3 weeks  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |                  |   |  |   |  |                                     |  |                                |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):               |  | history of hypertension  |                  |   |  |   |  |                                     |  |                                |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                     |  |                                |  |          |  |
|  |  |  |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                     |  |                                |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                     |  |                                |  |          |  |
|  |  | P.M. 19  |                  |   |  |   |  |                                     |  |                                |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY                              |  | STATE                          |  |          |  |
|  |  |  |                  |   |  |   |  |                                     |  |                                |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.                      |  | Dec. 14, 1977, to Jan 3, 1980  |                  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |                                     |  |                                |  |          |  |
| 22b. SIGNATURE   |  | DEGREE   |                  | 22c. DATE SIGNED  |  |   |  |                                     |  |                                |  |          |  |
| John O. Allin  |  | M.D.   |                  | Jan. 3, 1980  |  |   |  |                                     |  |                                |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |                  | 22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |                                     |  |                                |  |          |  |
| John O. Allin M.D.   |  | 8218 Wisconsin Ave. Bethesda, Md. 20814  |                  |   |  |   |  |                                     |  |                                |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY                              |  | STATE                          |  |          |  |
| Cremation  |  | 1/3/79   |                  | Metropolitan Crematory Alexandria, Va.  |  |   |  |                                     |  |                                |  |          |  |
| 24 FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |                  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                     |  |                                |  |          |  |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND  |  |  |                  | JAN 1980  |  |   |  |                                     |  |                                |  |          |  |

55

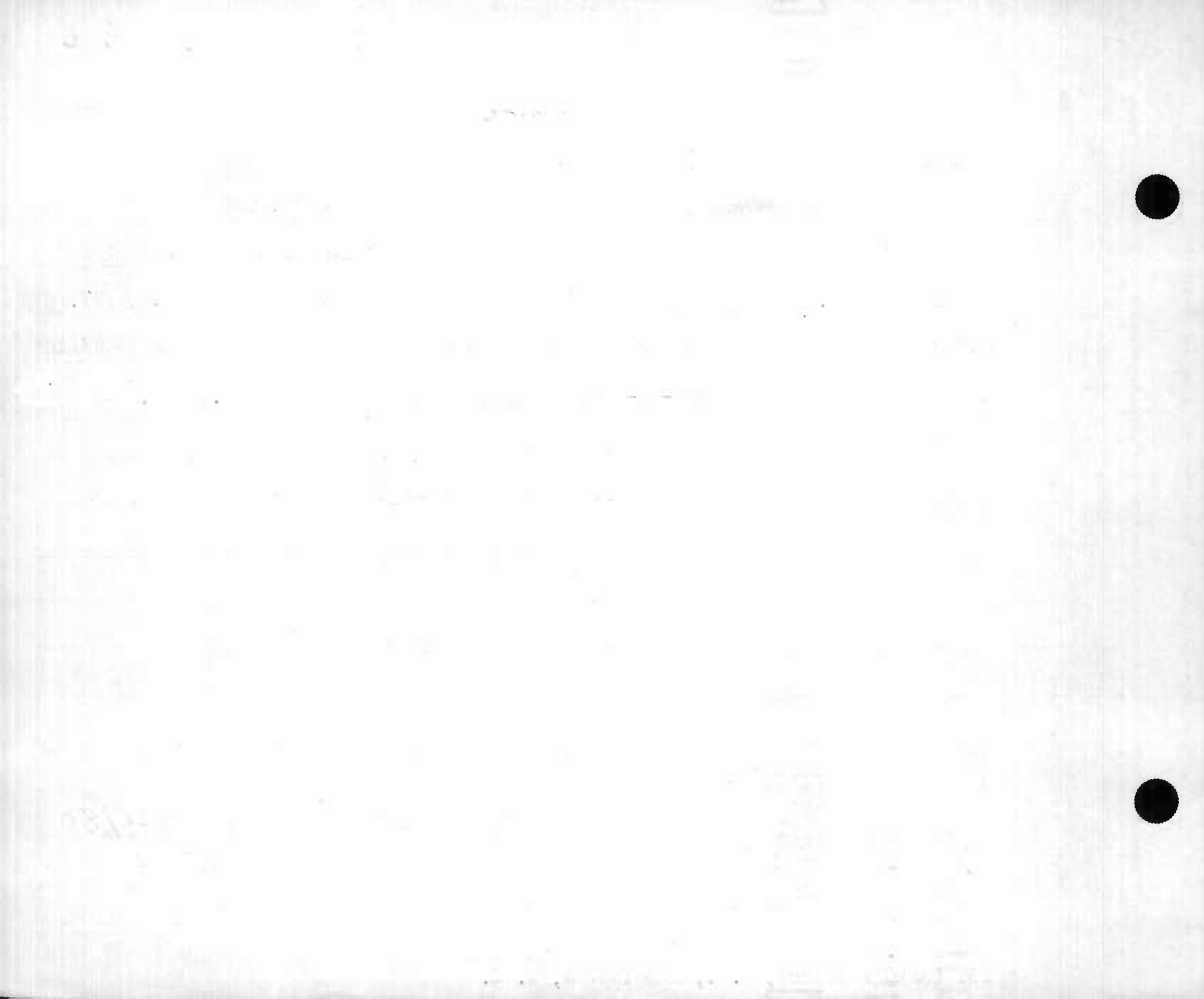
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  | REG. NO. 80 02186   |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>SURA UMANSKY  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan 20 80   |  |  | 2b. HOUR<br>3:40 AM                           |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV. 8, 1907  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>NONE   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                      |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Takoma Park  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY PR. GEORGES 13c. CITY OR TOWN HYATTSVILLE   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1406 MERRIMAC DRIVE, APT. 201   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CHIAM BUBAR   |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE<br>REVA (UNASCERTAINABLE)                                  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>214-92-9773  |  | 17 INFORMANT ADDRESS<br>JACOB UMANSKY, 8600 16th ST., APT. 615 SILVER SPRING, MD.  |   |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Intracerebral Bleeding<br>431 - DUE TO, OR AS A CONSEQUENCE OF<br>(b) uncontrolled Hypertension<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 1980 to 1/20 1980, that (I) (we) last saw the deceased alive on 1/18 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>MKarim   |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |  | 22c. DATE SIGNED<br>1/20/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOBARAK KARIM   |  |  |  | 22e. ADDRESS<br>201 Landovermall West, Landover, Md  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/21/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>JUDEAN MEMORIAL GARDENS  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>OLNEY MONTGOMERY MARYLAND    |  |   |  |
| 24 FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N.W., WASHINGTON, D. C.   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1980                               |  | 25b. REGISTRAR'S SIGNATURE<br>T. J. McCready  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 0 2 1 8 7  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELIZABETH W. VANAKEN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 31 80</b>   |  | 2b. HOUR<br><b>12.30 P.M.</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 26 94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>86</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>PG</b>   |  | 13c. CITY OR TOWN<br><b>Clinton</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edwin Hocking</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Frazer</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>None</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>107 40 6828</b>   |  | 17. INFORMANT ADDRESS<br><b>Same as above</b><br><b>Viola Mudge (Daughter)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b><br>5621<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Pathology</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/23/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diabetes</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/28/80</b> to <b>1/31/80</b> , that (I) (we) last saw the deceased alive on <b>1/31/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>H.L. Marter</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  | 22c. DATE SIGNED<br><b>1/31/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H.L. MARTER</b>   |  |  |  | 22e. ADDRESS<br><b>831 University Blvd E</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/4/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Hastings, New York</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hines/Rinaldi F.H.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 0 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>  |  |





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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                                    |   |  |  |  |  |  |  |
|---|--|--|------------------------------------|---|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8002138  |                                    | REG. NO.  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIETTE, -  |  |  | FIRST MIDDLE LAST<br>VANDENBUSSCHE |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1-2-80   |  |  | 2b. HOUR<br>845P<br>M  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>White   |                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-31-06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BELGIUM  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>BELGIUM  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO. MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA, MD.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |                                    |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>MONTG.  |                                    | 13c. CITY OR TOWN<br>BETHESDA   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>5007 ACACIA AVE.  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PIERRE Van HAELEN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JEANNETTE COOSEMANS   |                                    |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>NONE   |                                    | 17. INFORMANT<br>JANINE THYS (daughter)   |  | ADDRESS<br>SAME AS #13   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>4340</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u> |  |  |                                    |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 MIN</u><br><u>5 days</u><br><u>10 years</u>                          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Bronchopneumonia</u>   |  |  |                                    |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JAN 15</u> , 19 <u>75</u> , to <u>JAN 2</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>JAN 2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |                                    |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Thomas F. O'Connor MD</u>  |  |  |                                    | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>JAN 3, 1980  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS F. O'CONNOR MD  |  |  |                                    | 22e. ADDRESS<br>8218 WISCONSIN AVE BETHESDA MD  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>I-4-80  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONTG. MD.   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOSEPH CAWLER'S SONS INC  |  |  |                                    | ADDRESS<br>5120 WISG. AVE., S. W. WASH., D. C. 20015  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |

WINGFIELD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                  |  |  |  |
|--|--|--|--|---|--|---|--|----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8002189   |  |   |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                                     |  |
| William  |  | Arthur   |  | WAHL  |  | SR.   |  | January 30 1980                  |  | 12:40P <sup>M</sup>                          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                  |  | IF UNDER 24 HRS                              |  |
| Male   |  | Caucasian  |  | MONTH DAY YEAR<br>Oct. 23 1915  |  | 64 YRS.   |  | MONTHS DAYS                      |  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                  |  |  |  |
| Pennsylvania   |  | USA  |  |   |  | Montgomery  |  |                                  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR OCCUPATION                                 |  |                                  |  |  |  |
| Bethesda   |  | National Naval Medical Center  |  | Retired   |  | U.S. Coast Guard  |  |                                  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS              |  |  |  |
| Maryland   |  | Pr. George   |  | College park  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5205 Paducah Road                |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                  |  |  |  |
| John   |  | Carrie   |  |   |  |   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |                                  |  |  |  |
| Yes  |  | 1938-59  |  | 579 07 8968   |  | Mrs. Mary Wahl  |  | See item 13                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4349 Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>hemorrhagic intracerebral infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u></u>             |  |  |  |   |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                  |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                  |  |  |  |
| 22a. I certify that (I/ (this hospital) attended the deceased from Jan. 1, 1980, to Jan. 30, 1980, that (I/ (we) lost saw the deceased alive on Jan. 30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/ (we) (did) (didn't) view the body after death. |  |  |  |   |  |   |  |                                  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                                  |  |  |  |
| Joel West RAY  |  | M.D.   |  |   |  | Jan. 30, 1980   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |                                  |  |  |  |
| Joel West RAY  |  | National Naval Medical Center, Bethesda, Md.   |  |   |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                  |  |  |  |
| Burial   |  | 2/2/80   |  | Fort Lincoln Cemetery   |  | Bridensburg Pr. Co. Geo.  |  |                                  |  | STATE Md.                                    |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |  |  |
| Francis Gasch's Sons   |  | Hyattsville, Md.   |  | FEB 05 1980   |  | P. J. McCreedy  |  |                                  |  |  |  |

RECEIVED  
OFFICE OF THE  
ATTORNEY GENERAL  
JAN 10 1964

RECEIVED  
JAN 10 1964

Handwritten notes and signatures are visible across the page, including a large signature in the center and several smaller ones at the bottom. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| Items 12a, 15, 16b, 22a. G540<br>1- STATE FOR 2/21/80 dad REGISTRAR  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| DOROTHY B. WALESKI   |  |  |  |  |  | 1 10 80   |  | 9:00 PM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |
| Female   |  | White  |  | 8-02-16  |  | 63 YRS  |  | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Texas  |  | U.S.A.   |  |  |  | MONTGOMERY COUNTY MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| OLNEY  |  | MONTGOMERY GENERAL HOSPITAL  |  |  |  | Senior Director   |  | N.I.H.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS  |  |
| 13a. STATE CITY COUNTY M.D. MONT. Rockville  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5702 vandergrift Ave.  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)                            |  |  |  |
| Bailey Douglas   |  |  |  |  |  | Alice Ashiter Hill  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| X  |  |  |  |  |  | 124-842859  |  | GEORGE WALESKI (SAME AS #13)                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure  |  |  |  |  |  |   |  |  |  |
| 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |   |  |  |  |
| (b) Extensive hepatic metastasis   |  |  |  |  |  |   |  |  |  |
| (c) Adenocarcinoma of Colon  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (If any)   |  |  |  |  |  |   |  |  |  |
| Intermittent cardiac arrhythmia  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from July 19 80 to 10 Jan 80, that (1) (most) saw the deceased alive on 10 Jan 80 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| Donald E. Dillion  |  |  |  |  |  | MD  |  | 11 Jan 80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |
| DONALD E. DILLION  |  |  |  |  |  | Bill Prince Phillip Dr, Olney Md                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| CREMATION  |  | 1-11-80  |  | CEDAR HILL CREMATORY   |  | SOUTH MARYLAND P.G. MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| W. C. CHAMBERS (ADDRESS)   |  |  |  |  |  | JAN 16 1980   |  | Lester K. K... ..  |  |

1957 M. 2. 11

(1957 M. 2. 11)

1957 M. 2. 11

1957 M. 2. 11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE A "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| FOR<br>1- STATE REGISTRAR   |  |                  |  |   |  |                               |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |                          |  |  |  |  |  |  |  | REG. NO. 02191 |  |  |  |
|---|--|------------------|--|---|--|-------------------------------|--|---|--|---|--|---|--|--|--|--------------------------|--|--|--|--|--|--|--|----------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) DAVID HENRY WALLACE   |  |                  |  | 2b. DATE KNOWN OF DEATH ESTIMATED   |  |                               |  | 2c. DATE PRONOUNCED DEAD  |  |   |  | 2d. DATE KNOWN OF DEATH ESTIMATED   |  |  |  | 2e. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |                |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>Feb 27 1963   |  | 6. AGE (IN YEARS)<br>63 YRS.  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Syl. Spg   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>15501 Prince Frederick Way N.O.A.A. |  |                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Exec. U.S. GOVT.   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 13a. STATE<br>Md  |  |                  |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Syl. Spg |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>15501 Prince Frederick Way |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES L. WALLACE  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY P. CECIL  |  |                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-30-4338   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 17. INFORMANT<br>ELIZABETH M. WALLACE   |  |                  |  | 18. ADDRESS<br>SAME AS # 13   |  |                               |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Myocardial Dis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Was shoveling snow  |  |                  |  |   |  |                               |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 19a. DATE OF OPERATION<br>None  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                               |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |                               |  |   |  |   |  | 22b. TITLE (SPECIFY)<br>M.D. Dep  |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| ACTUAL SIGNATURE<br>John S. Rogers  |  |                  |  | DATE SIGNED<br>Jan 5, 1980  |  |                               |  | MEDICAL EXAMINER  |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) JOHN S. ROGERS M.D.  |  |                  |  | ADDRESS<br>1919 SEMINARY RD SILVER SPRING, MD.  |  |                               |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL   |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 23b. DATE<br>I-8-80   |  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SUDLERSVILLE CEME.  |  |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUDLERSVILLE MD.  |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME JOSEPH CAWLER'S SONS INC.<br>ADDRESS 6180 WILCO AVE., S. W. WASH., D. C. 20010   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1980  |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br>History McCreedy  |  |   |  |   |  |  |  |                          |  |  |  |  |  |  |  |                |  |  |  |





(12)



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002192

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catharine Hinda Wausau (Smith)</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 28, 1980</b>                |   |   | 2b. HOUR<br><b>2:00PM</b>  |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 25, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                 |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Mont.</b>   |   | 13c. CITY OR TOWN<br><b>S.S.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>14006 New Hamp. Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Vaszauskas</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catharine UNK</b>         |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>None</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>186 09 5359</b> |   |   | 17. INFORMANT <b>Same as above</b><br><b>A Richard Smith (Husband)</b>               |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO SCLEROSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Severe Anoxic Encephalopathy</b>   |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FIRM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 25</b> 19 <b>80</b> to <b>Jan 28</b> 19 <b>80</b> , that (I) (we) last saw the deceased on <b>Jan 28</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |   |   |   |  |   |  |  |  |
| 23a. SIGNATURE<br><b>Pedro I. Matias</b>  |  |   | DEGREE  |   |   | 23b. DATE SIGNED<br><b>1-28-80</b>   |   |  |  |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PEDRO I. MATIAS MD.</b>   |  |   | 23d. ADDRESS<br><b>180 Prince Philip Dr Olney, Md 20832</b>                   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>1/29/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory Brentwood PG Md.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Honora Rinaldi</b>   |  |   | ADDRESS<br><b>11800 N.H. Ave. S.S. Md.</b>                                    |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1980</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Honora Rinaldi</b>  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RECEIVED  
JAN 10 1964



100% COTTON  
MADE IN U.S.A.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 0 2 1 9 3   |  |   |  |  |  |                                       |  |  |  |                                    |  |
|---|--|---|--|---|--|---|--|--|--|---------------------------------------|--|--|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>STUART   |  | MIDDLE<br>MAUPIN  |  | LAST<br>Weedon  |  | 2a. DATE OF DEATH<br>MONTH<br>1  |  | DAY<br>5                              |  | YEAR<br>80                                   |  | 2b. HOUR<br>12:30pm                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH<br>12   |  | DAY<br>15   |  | YEAR<br>1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 |  | 7. IF UNDER 1 YEAR<br>MONTHS<br>YRS          |  | 8. IF UNDER 24 HRS<br>HOURS<br>MIN |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD   |  |  |  |                                       |  |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1719 Munson ST |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>REFRIGERATION  |  |  |  |                                       |  |  |  |                                    |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>Wheaton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1719 Munson ST  |  |                                       |  |  |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST<br>Chancelor   |  | MIDDLE<br>Weedon  |  | LAST<br>Weedon  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Bessie   |  | MIDDLE<br>MAUPIN   |  | LAST<br>MAUPIN                        |  |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>W.W.T   |  | 17. INFORMANT<br>Bessie M. Weedon   |  | ADDRESS<br>2719 Munson ST<br>Wheaton MD   |  |  |  |                                       |  |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma and Brain Metas</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>other multiple metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  |                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                    |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                       |  |  |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  |   |  |  |  |                                       |  |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE                                 |  |  |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10.24</u> , 19 <u>79</u> , to <u>1.5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1.5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |                                       |  |  |  |                                    |  |
| 22b. SIGNATURE<br><u>Felix Castellon</u>  |  | DEGREE  |  | 22c. DATE SIGNED<br>1.6.80  |  |   |  |  |  |                                       |  |  |  |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FELIX CASTELLON, M.D.  |  | 22e. ADDRESS<br>12221 Cedar Hill Dr. S.S., MD 20904   |  |   |  |   |  |  |  |                                       |  |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-8-1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Richardsville Cem   |  | 23d. LOCATION<br>CITY OR TOWN<br>Richardsville  |  | COUNTY<br>VIRGINIA   |  | STATE                                 |  |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br>Clare Fun. Home, Inc Culpeper, Va.  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 12 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u>  |  |   |  |  |  |                                       |  |  |  |                                    |  |

Discrepancy in amount of cash received  
from the bank

JAN 1 1980



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 8002194   |  | REG. NO.  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Irmgard Clara Weidlich</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 22 80</b>   |  | 2b. HOUR <b>11 50 AM</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 31, 1889</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.                                    |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>   |  |
| 13a. STATE <b>Maryland</b>   |  |   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Takoma Park</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar Beyer</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Andres</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>214-52-7070</b>   |  | 17. INFORMANT ADDRESS <b>641 Houston Avenue Takoma Park, Md.</b>                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary arrest</b><br><b>4140</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>longstone heart failure</b><br>(c) <b>arteriosclerotic heart disease</b>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 weeks</b><br><b>years</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>diabetes mellitus</b>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 3, 1980</b> to <b>Jan 22, 1980</b> , that (I) (we) last saw the deceased alive on <b>Jan 21, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Margaret S. Choa</b>   |  |   |  | 22c. DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22d. DATE SIGNED <b>1-22-80</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARGARET S. CHOA</b>  |  |   |  | 22f. ADDRESS <b>1111 Spring St Silver Spring Md</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-25-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington, Virginia</b>     |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>                                |  |   |  |
| 5130 Wisconsin Ave., N. W., Washington, D. C.  |  |   |  |   |  |   |  |   |  |

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

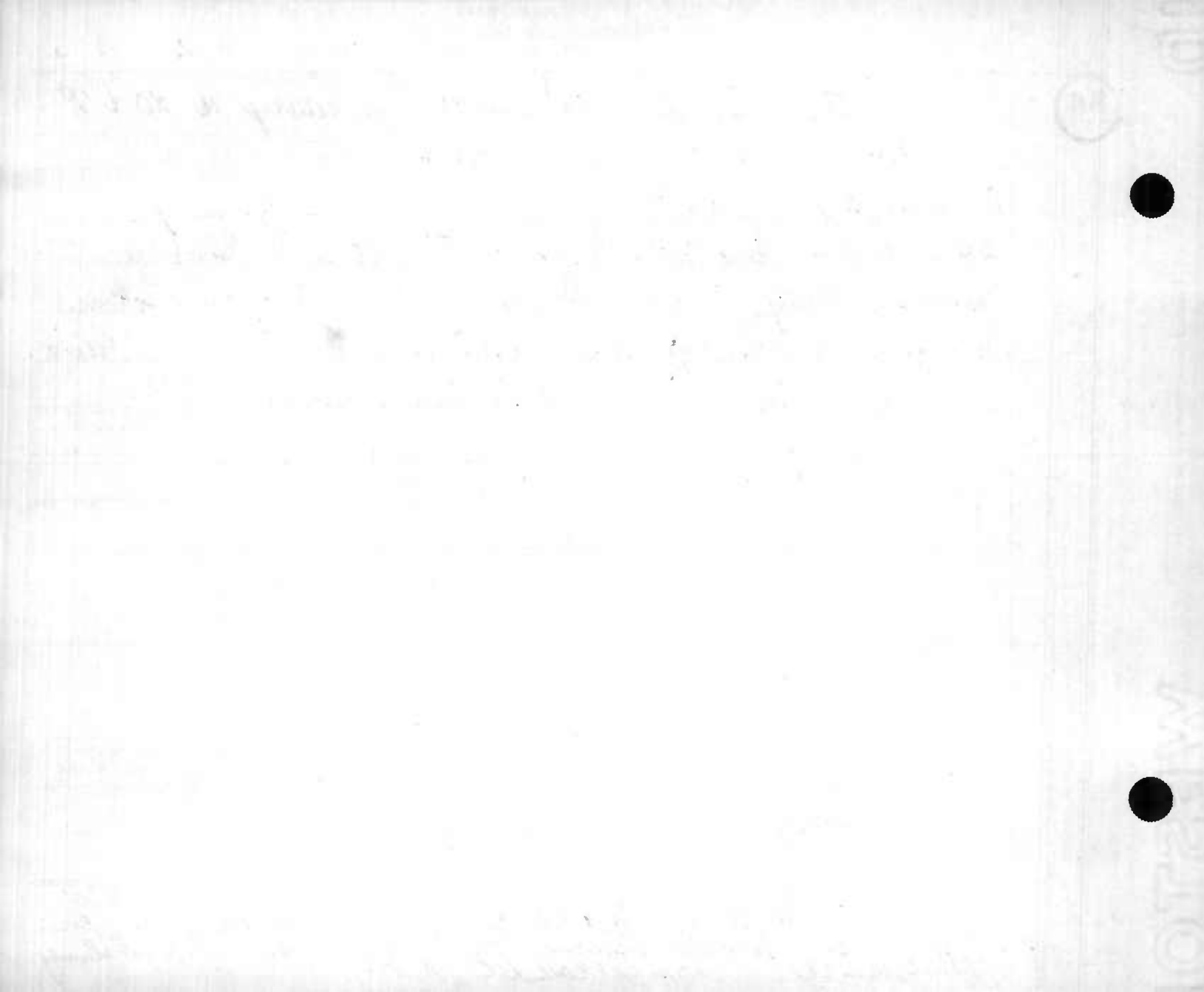


1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 1 9 5  
REG. NO

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Victor Emile Werner</b>   |   |  | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 16 80</b>  |  | 7b. HOUR<br><b>6:18</b> M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 22-1914</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Brockland N.Y.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Interna Park</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Hosp. Admitted</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired U.S. Government</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY OR TOWN<br><b>Maryland Monty Interna Park</b>   |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13c. STREET ADDRESS<br><b>7418 Kelly Ave. Interna</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christoffer A. Christoffersen</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cathryn Hick</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>Yes WWI</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>D54-03-3889</b>   |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Geraldine J. Werner (13c)</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>80</b> , to <b>1/16</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |  |  |  |  |
| 27b. SIGNATURE<br><b>Patricia J. Stage</b>   |   | DEGREE   |  | 27c. DATE SIGNED<br><b>1/16/80</b>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 27e. ADDRESS   |  |  |  |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial Jan 18-1980</b>   |   | 28b. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek</b>  |  | 28c. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore D.C.</b>            |  |
| 29. FUNERAL DIRECTOR<br><b>Arthur Walters</b>  |   | 30. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1980</b>   |  | 31. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                           |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002196

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |                         |  |  |  |   |   |
|---|-------------------------|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Frances A. West</i>                        |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1/3/80</i> |  | 2b. HOUR<br><i>8:15</i> P.M.              |   |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>02/14/88</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>91</i>         |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>WASHINGTON, D. C.</i>             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                 |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Bel Air Health Care Center</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>CASHIER</i>                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>KANNS DEPT STOR</i> |
| 13a. STATE<br><i>Md.</i>  |                         | 13b. COUNTY<br><i>Montgomery</i>   | 13c. CITY OR TOWN<br><i>Rockville</i>                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>                          |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>AGNES UNKNOWN N</i>  |  | 13e. STREET ADDRESS<br><i>XXXXXXX XXXXXX XXXX</i><br><i>199 ROLLINS AVENUE</i> <i>XXXX</i>                               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i> |                         | 16b. SOCIAL SECURITY NO.<br><i>578-07-6111</i>   |  | 17. INFORMANT<br><i>GRANDDAUGHTER</i><br><i>CAROLE L. CULLINANE</i><br><i>4712 POWDER HOUSE</i><br><i>ROCKVILLE, MD.</i> |   |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis and</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>arteriosclerotic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>Years</i> |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <i>11-27-79</i> 19 to <i>1-3-80</i> 19, that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <i>1-3-80</i> 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Marie J. Morris</i>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1-3-80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. (Marie J.) Morris</i>   |  | 22e. ADDRESS<br><i>415 Colie Ln. Silver Spring Md.</i>                 |  |  |  |   |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>              |  | 23b. DATE<br><i>1/5/80</i>                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ROCK CREEK CEMETERY</i> |  | 23d. LOCATION<br>WASHINGTON, D. C. COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS</i><br><i>XXXXXX</i> |  | ADDRESS<br><i>500 Univ. Blvd. W. Silver Spring, Md.</i> |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1980</i>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony J. Kennedy</i> |  |

1. TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WASHINGTON, D. C. U.S.A.

XX

CASHIER

WASH. D.C. 20540

FOOT LOCKER WORKS  
1000 17TH ST. N.W.  
WASHINGTON, D.C.

FOOT LOCKER WORKS  
1000 17TH ST. N.W.  
WASHINGTON, D.C.

ADAMS

PARSONS

UNION

COMMUNICATIONS

CAROL E. COLLINS

NO

INTERNAL 115100 FOOT LOCKER WORKS WASHINGTON, D.C.

FRANKS J. COLLINS

RECEIVED

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8002197

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMIL WESTLAND</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 8, 1980</b>                            |  | 2b. HOUR<br><b>10<sup>40</sup> AM</b>                           |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16 1894</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS                                     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>u.s.a.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Wheaton</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RANDOLPH HILLS NURSING HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool Maker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed.</b>      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Kensington</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>3003 Decatur Ave.</b>                                      |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick W Westland</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Razenowich</b>               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>350-26-3504 A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Irngard Williams, Daughter. Same as item 13.</b>      |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PROSTATE</b><br><b>185-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 YR</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>about 11/79</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AS ABOVE</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/80</b> to <b>1/8</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1/8</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.                                    |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Richard H. Pollen, M.D.</b>  |   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1-8-80</b>                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard H. Pollen, M.D.</b>   |   |   | 22e. ADDRESS<br><b>10400 Conn. Ave. Kensington, Md.</b>                               |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>1/10/1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland.</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Lawler's Sons Inc.<br/>5130 Wisc Ave., N.W. Wash., D.C.</b>   |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>   |   |  |   |

MEDICAL CERTIFICATION

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BP

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(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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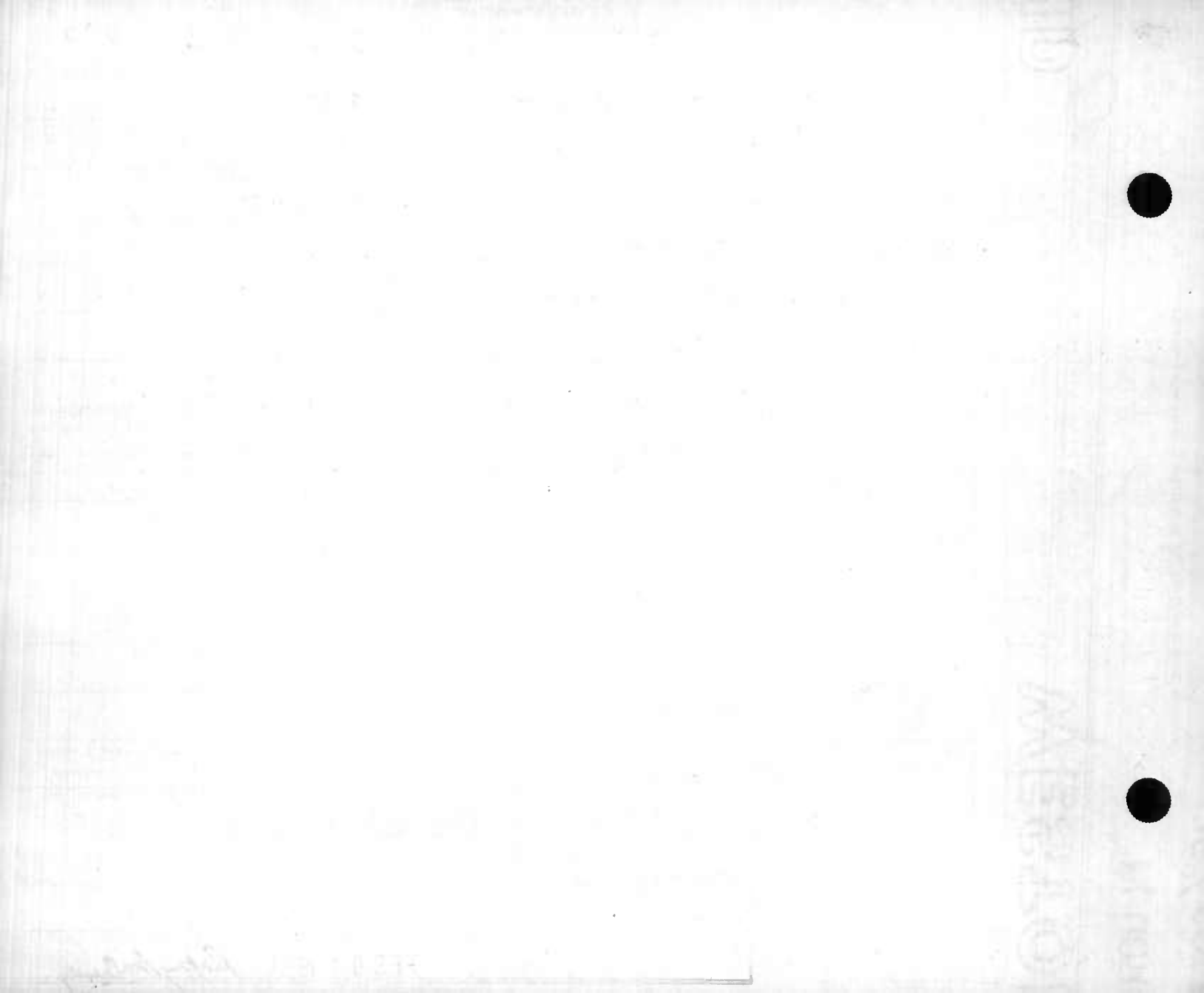
1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edwin F Wheeler</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-30-80</b>                  |   |   | 2b. HOUR<br><b>2:43 P.M.</b>   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 3, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>406 North Park Ave.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Wheeler</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie List</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-12-6751</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>1202 Downs Dr. Silver Spring, Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary arteriosclerosis</b> |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Cerebral arteriosclerosis</b>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 31, 19 79</b> to <b>Jan 30, 19 80</b> , that (I) (we) lost saw the deceased alive on <b>Jan 17, 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>T. James Waters M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/30/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. JAMES WATERS, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>5530 Wisconsin Ave. Chevy Chase, Md.</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 2, 1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi Funeral Home</b><br><b>11800 New Hampshire Ave. Silver Spring, Md.</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 04 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreary</b>   |  |

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

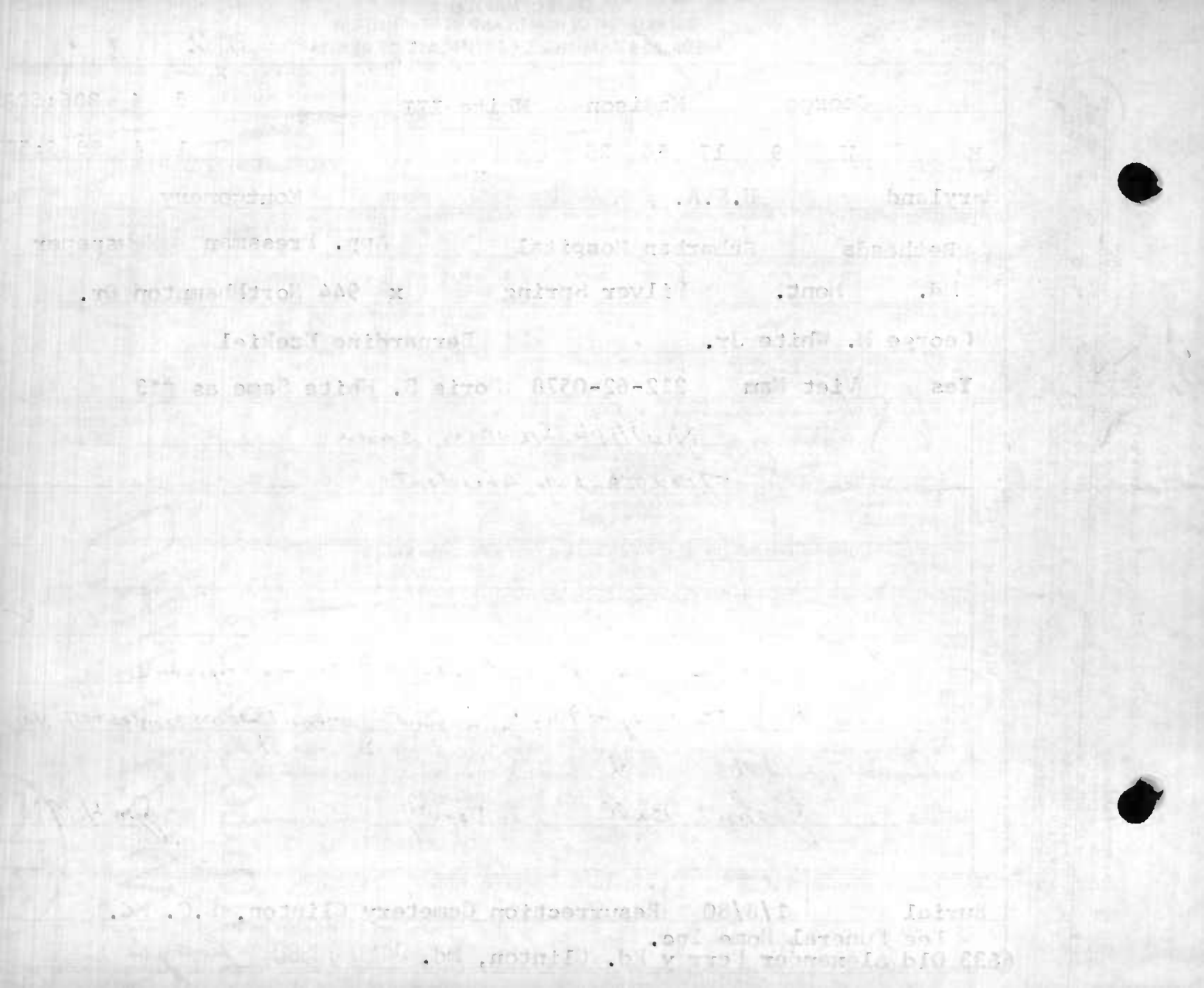
DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02199

|  |  |                                      |  |   |  |                   |  |   |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
|--|--|--------------------------------------|--|---|--|-------------------|--|---|--|---|--|---|--|------------------|--|---|--|---|--|----------|--|--------------|--|-------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | 2a. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>George   |  | MIDDLE<br>Madison |  | LAST<br>White III   |  | 2b. DATE KNOWN<br>OF<br>DEATH<br>ESTI-<br>MATED |  | MONTH<br>1  |  | DAY<br>4         |  | YEAR<br>1980                                |  | 2d. HOUR<br>6:50A   |  |          |  |              |  |                   |  |
| 3. SEX<br>M  |  | 4. RACE<br>W                         |  | 5. DATE OF BIRTH<br>MONTH<br>9  |  | DAY<br>17         |  | YEAR<br>54  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>25 YRS.   |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS<br>HOURS<br>MIN.   |  | IF UNDER 24 HRS. |  | 7c. DATE<br>PRONOUNCED<br>DEAD              |  | MONTH<br>1  |  | DAY<br>4 |  | YEAR<br>1980 |  | 2d. HOUR<br>6:50A |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |  |                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |                                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>App. Pressman   |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Newspaper   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 13a. STATE<br>Md.  |  |                                      |  | 13b. COUNTY<br>Mont.  |  |                   |  | 13c. CITY OR TOWN<br>Silver Spring  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  |  | 13e. STREET ADDRESS<br>944 Northhampton Dr. |  |   |  |          |  |              |  |                   |  |
| 14. FATHER'S NAME<br>FIRST<br>George M.  |  |                                      |  | MIDDLE<br>White Jr.   |  |                   |  | LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Bernardine   |  |                  |  | MIDDLE<br>Ezekiel                           |  |   |  | LAST     |  |              |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                                      |  | 16b. SOCIAL SECURITY NO.<br>Viet Nam  |  |                   |  | 17. INFORMANT<br>Doris S. White Same as #13   |  |   |  | ADDRESS   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries, same.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) <u>Trauma Auto Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                                      |  |   |  |                   |  |   |  |   |  |   |  |                  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |          |  |              |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                      |  |   |  |                   |  |   |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 19a. DATE OF OPERATION   |  |                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |   |  |   |  |   |  |                  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |              |  |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3 <sup>PM</sup> 1-4 1980   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>Lost control of the car on off road.</u>                                |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |  |                                      |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><u>Beltsy 495 + Kensington Pkwy. Bethesda</u>                 |  |                   |  | 21f. LOCATION<br>STREET<br><u>Montgomery</u>  |  |   |  | CITY OR TOWN<br><u>Bethesda</u>   |  |                  |  | COUNTY<br><u>Montgomery</u>                 |  | STATE<br><u>Md.</u>   |  |          |  |              |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                      |  |   |  |                   |  |   |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| ACTUAL<br>SIGNATURE<br><u>John S. Ball</u>   |  |                                      |  | TITLE (SPECIFY)<br><u>Deputy</u>  |  |                   |  | MEDICAL EXAMINER  |  |   |  | DATE<br>SIGNED<br><u>Jan 4, 1980</u>  |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                                      |  | ADDRESS   |  |                   |  |   |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                      |  | 23b. DATE<br>1/8/80   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cemetery Clinton, P.G. Md.   |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>Clinton  |  |                  |  | COUNTY<br>P.G.                              |  | STATE<br>Md.  |  |          |  |              |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lee Funeral Home Inc.  |  |                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1980  |  |                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |   |  |                  |  |   |  |   |  |          |  |              |  |                   |  |

6633 Old Alexander Ferry Rd. Clinton, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8002200   |  |   |  |   |
|---|--|--|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES L. WHITEMORE  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-5-80   |  |   |  | 2b. HOUR<br>7:15 PM                       |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>9 30 00  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. DC   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                         |  |   |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MODE OF WORK (LIFE))<br>C. P. Tel. Co. |  | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3000 mCComas   |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James H. Whitemore   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH E. Lindsay   |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>UNK   |  | 17. INFORMANT ADDRESS<br>Mary E. Harris 15416 Wembrough St. S.W. MD 20904  |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5315 PERITONITIS<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured gastric ulcer<br>DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC ULCER<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>7 days<br>YEARS |  |  |  |  |  |   |  |   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |   |  |   |
| 19a. DATE OF OPERATION<br>12/28/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ruptured gastric ulcer   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT 19 79, to 1/5 80, that (I) (we) lost<br>saw the deceased alive on 1/5/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (do not) view the body after death.                                       |  |  |  |  |  |   |  |   |
| 22b. SIGNATURE<br>Thos G. Ward M.D.   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br>1/6/80  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos G. Ward, MD   |  |  |  | 22e. ADDRESS<br>6116 Robinwood, Bethesda, Md 20814   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/9/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet   |  | 23d. LOCATION<br>CITY OR TOWN NASH. DC STATE                                  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME W. W. TALTA VULL ADDRESS 4748 Wisc. Ave. NW  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                     |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

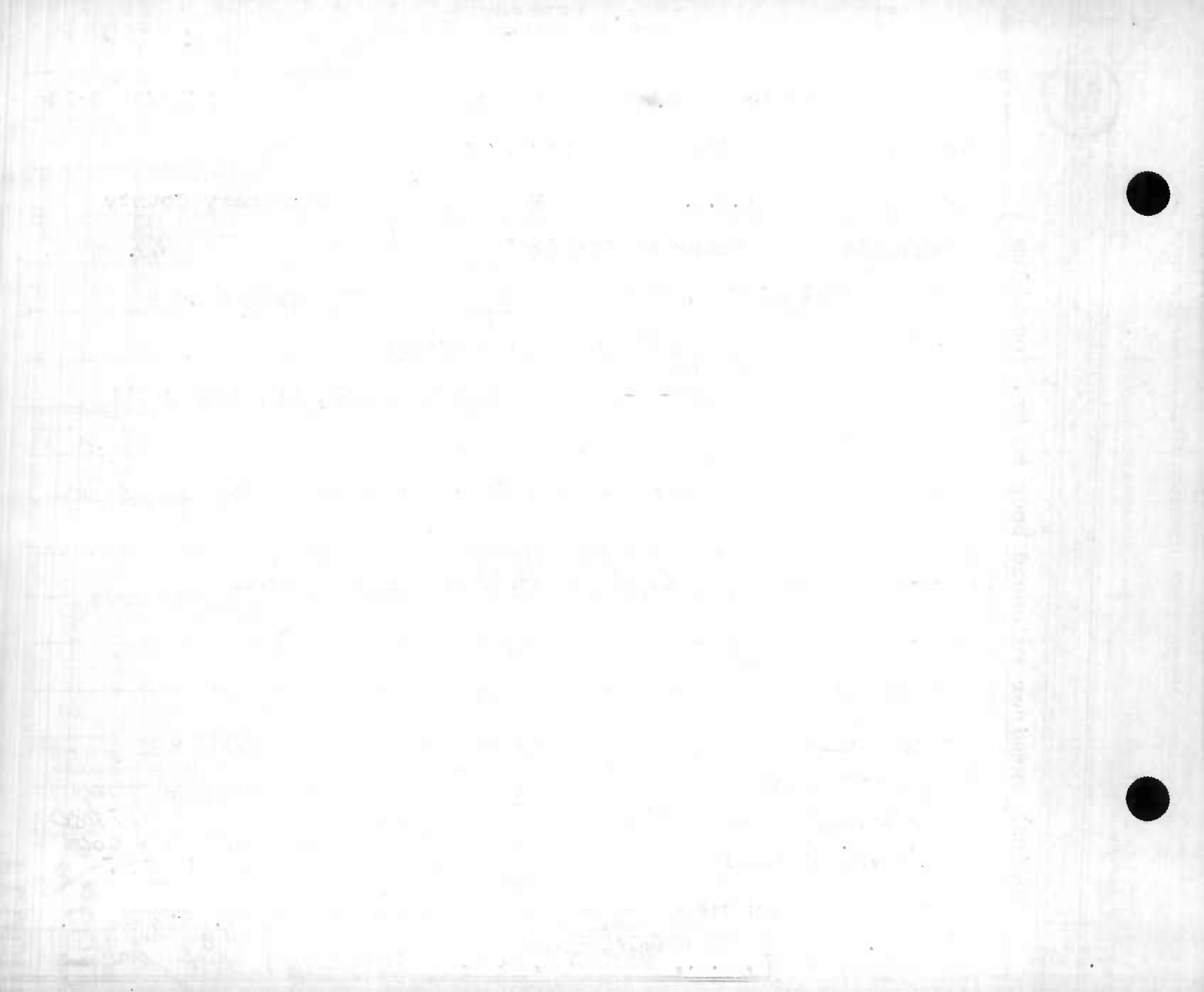
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner released body to Dr. Rosenblum

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. DATE OF DEATH                                 |  | MONTH DAY YEAR   |  | 2. DECEASED NAME (TYPE OR PRINT)                                   |  | 3. SEX                                 |  |
|  |  | 1/16/80  |  | 3:10 PM  |  | Bessie B. Wiesman  |  | Female                                 |  |
| 4. RACE  |  | 5. DATE OF BIRTH                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                           |  | 8. CITIZEN OF WHAT COUNTRY?            |  |
| White  |  | 12/28/01   |  | 78 YRS.  |  | RUSSIA   |  | U.S.A.                                 |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 13. KIND OF BUSINESS OR INDUSTRY       |  |
| Montgomery County  |  | Bethesda   |  | Suburban Hospital  |  | CLERK  |  | U.S. GOV'T.                            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                         |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                       |  | 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT ADDRESS                  |  |
| NATHAN   |  | FAIGARUCHEL                                      |  | NO   |  | 579-54-8635  |  | BENJAMIN WIESMAN, son, same as #13     |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.     |  | 22. DUE TO, OR AS A CONSEQUENCE OF (b)                             |  | 23. DUE TO, OR AS A CONSEQUENCE OF (c) |  |
| CARDIAC ARREST   |  | 10 MIN.  |  | 4292   |  | ARTERIOSCLEROTIC CARDIOVASC. DIS.                                  |  | YEARS                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| GASTROENTERITIS, ORGANIC BRAIN SYNDROME  |  |  |  |  |  |  |  |  |  |
| 24. DATE OF OPERATION  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 26. AUTOPSY?   |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  | 28. DATE SIGNED                        |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 1/17/80                                |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 30. TIME OF INJURY                               |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 33. LOCATION                           |  |
|  |  | P.M. 19  |  |  |  |  |  | CITY OR TOWN COUNTY STATE              |  |
| 34. INJURY OCCURRED  |  | 35. PLACE OF INJURY                              |  | 36. LOCATION   |  | 37. DATE REC'D. BY REGISTRAR                                       |  | 38. REGISTRAR'S SIGNATURE              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  | STREET CITY OR TOWN COUNTY STATE   |  | JAN 21 1980  |  | HARRY McCREEDY                         |  |
| 29. I certify that (I) (this hospital) attended the deceased from 2/28 19 76 to 1/16 19 80, that (I) (we) last saw the deceased alive on 1/8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 30. SIGNATURE  |  | 31. DEGREE                                       |  | 32. ADDRESS  |  | 33. DATE SIGNED  |  | 34. REGISTRAR'S SIGNATURE              |  |
| Daniel Rosenblum   |  | MD   |  | 10400 CONN. AVE STE 606 KENSINGTON, MD 20795   |  | 1/17/80  |  |  |  |
| 35. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 36. ADDRESS                                      |  | 37. DATE REC'D. BY REGISTRAR   |  | 38. REGISTRAR'S SIGNATURE  |  | 39. REGISTRAR'S SIGNATURE              |  |
| DANIEL ROSENBLUM   |  |  |  | JAN 21 1980  |  | HARRY McCREEDY   |  |  |  |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 41. DATE   |  | 42. NAME OF CEMETERY OR CREMATORY  |  | 43. LOCATION   |  | 44. REGISTRAR'S SIGNATURE              |  |
| BURIAL   |  | 1/18/1980  |  | MOUNT LEBANON CEMETERY   |  | ADELPHI PR. GEORGES MD.  |  |  |  |
| 45. FUNERAL HOME   |  | 46. DATE   |  | 47. NAME OF CEMETERY OR CREMATORY  |  | 48. LOCATION   |  | 49. REGISTRAR'S SIGNATURE              |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C.  |  | JAN 21 1980                                      |  | MOUNT LEBANON CEMETERY   |  | ADELPHI PR. GEORGES MD.  |  |  |  |





1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 0 2 2 0 2

|  |                  |   |   |   |                     |
|--|------------------|---|---|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Astor (NMN) Williams                  |                  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 15, 1980 |   | 2b. HOUR<br>8:55 PM |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 1, 1922   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky                        |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center, Bethesda, Md. |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD  |                     |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman |                  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance          |   |                     |
| 13a. STATE<br>Kentucky   |                  |   |   |   |                     |
| 13b. COUNTY<br>Payette   |                  | 13c. CITY OR TOWN<br>Lexington  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Calvin Williams                    |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louisa Lewis   |   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>412-16-2332   |   | 17. INFORMANT<br>ADDRESS<br>Same as above<br>Mrs. Wilma J. Williams, wife   |                     |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiogenic Shock

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
11 Days4149  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) S/P RE-DO CORONARY BYPASS SURGERY

11 Days

DUE TO, OR AS A CONSEQUENCE OF

(c) CORONARY ARTERY DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

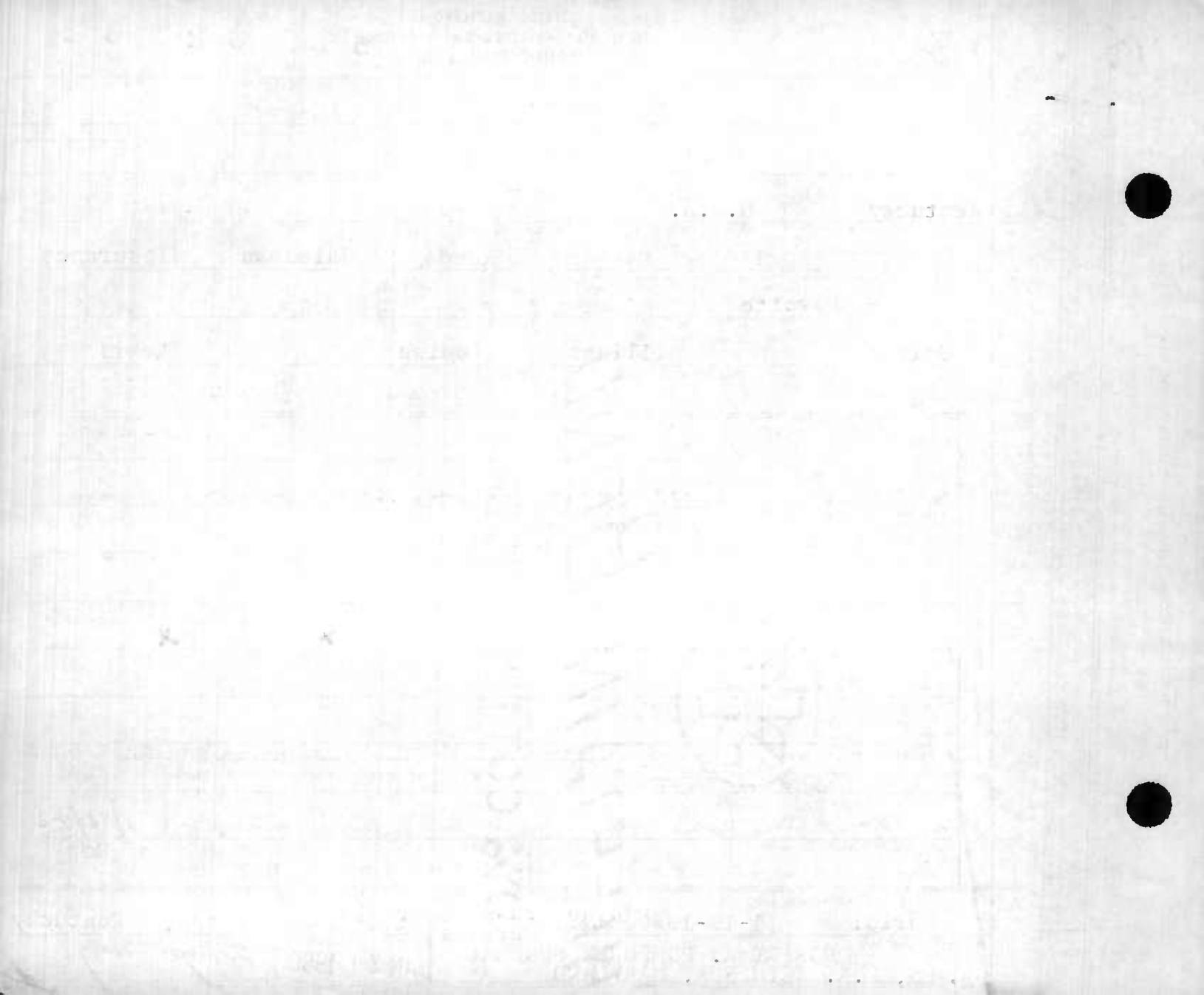
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from December 31, 1979, to January 15, 1980, that (we) lost<br>saw the deceased alive on January 15, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (We) (did) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Karl J. Karlson, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/16/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL J. KARLSON  |  |  |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md. 20205  |  |  |  |

|  |  |                        |  |  |  |   |  |
|--|--|------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                       |  | 23b. DATE<br>1-19-1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lexington Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lexington, Kentucky |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL<br>HOMES, P.A. BETHESDA, MARYLAND |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1980             |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar. After death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |                                 |   |   |  |
|--|--|--|--|--|--|--|---------------------------------|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |                                 |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Raymond Luther Wilson   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR<br>January 1 1980 1:28 P.M. |  |                                 |   |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Apr. 2, 1921  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS                                  |                                 | IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                  |                                 |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hosp. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                 | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>Md.  |  |  |  |  | 13b. COUNTY<br>Pr. Geo.  |  | 13c. CITY OR TOWN<br>Beltsville |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Luther Wilson  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Odean Gross             |  |                                 |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>IWW# 064-12-1737   |  | 17. INFORMANT ADDRESS<br>Ruth Wilson (wife) same as #13  |  |  |                                 |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>unknown</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic lung cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |                                 |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |  |  |  |  |  |                                 |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                 |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                                 |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from April 19 79, to Jan 1 19 80, that (1) we last saw the deceased alive on Dec 31 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |  |  |  |  |  |                                 |   |   |  |
| 22b. SIGNATURE OF PHYSICIAN<br>[Signature]   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |  |  |                                 | 22c. DATE SIGNED<br>1/1/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. NAIDAK  |  |  |  | 22e. ADDRESS<br>1725 Belvidere Rd Baltimore  |  |  |                                 |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-5-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. PK.   |  | 23d. LOCATION CITY OR TOWN<br>Liaurel, Pr. Geo. Md.                    |                                 |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br>George R. Snowden  |  |  |  | 24b. ADDRESS<br>246 N. Wash St Rockville, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 1 1980                            |                                 | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |  |

23

4184-100103-000

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8002204   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 2b. HOUR   |  |  |  |
| SELMA D. WILSON   |  |  |  | 1/5/80 5:52 P.M.   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | Cauc.  |  | 2 28 1900  |  | 79 YRS.  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7c. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Wash., D.C.   |  | U.S.A.   |  | Montgomery   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda  |  | Suburban Hospital  |  | Ret. Buyer-Clothing  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  | 13e. STREET ADDRESS  |  |  |  |
| Md. Mont. Rockville   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 299 - Hurley Avenue  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Samuel Steiner  |  |  |  | Leah Garner  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |  |  |
| No  |  | 577-10-0322  |  | 90-Monroe St. Rockville, Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension 70ARS DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis 11                               |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5/80 to 1/5/80, that (I) (we) lost saw the deceased alive on 1/5/80 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |  |  |
| Thos. G. Ward M.D.  |  | ATTENDING PHYSICIAN  |  | MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>          |  | 1/6/80   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 23b. ADDRESS   |  |  |  |  |  |
| Thos. G. Ward   |  | 6116 Robinwood, Bethesda, Md. 20834  |  |  |  |  |  |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23d. DATE  |  | 23e. NAME OF CEMETERY OR CREMATORY   |  | 23f. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 1-8-1980   |  | Ft. Lincoln Cem.   |  | Brentwood Pr. Geo. Md.   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Nalley's F.H. Inc.  |  | Mt. Rainier, Md.   |  | JAN 10 1980  |  | [Signature]  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 15 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |   |   |  |   |  |  |                            | REG. NO. 02205  |                                  |  |  |                                  |  |
|--|--|--------------|---|---|--|---|--|--|----------------------------|---|----------------------------------|--|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |              | FIRST MIDDLE LAST<br>Virginia C. Wilson |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  |  | MONTH DAY YEAR<br>1/2 1980 |   | 2b. HOUR<br>12 <sup>15</sup> P M |  |  |                                  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B |   | 5. DATE OF BIRTH<br>(LAST BIRTHDAY) MONTH DAY YEAR<br>10/10/29  |  | 6. AGE (IN YEARS)<br>50 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS  |                            | IF UNDER 24 HRS.<br>HOURS MIN.  |                                  | 7c. DATE PRONOUNCED DEAD<br>Jan 12 1980                |  | 2d. HOUR<br>12 <sup>15</sup> P M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |              |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            |   |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |              |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            |   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |                                  |  |
| 13a. STATE<br>Md   |  |              |   | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Bethesda   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 13e. STREET ADDRESS<br>4711 Arondale Dr.  |                                  |  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Butler  |  |              |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Naomi Butler                         |  |  |                            |   |                                  |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |              |   | 16b. SOCIAL SECURITY NO.<br>579 44 3332   |  | 17. INFORMANT ADDRESS<br>703 Tenza Terrace Fort Myer, V.A<br>Gordon Butler Son, 22211 |  |  |                            |   |                                  |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Artery Disease - Aorta</u><br>8147<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Cerebral Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pedestrian Auto-accident</u>                                    |  |              |   |   |  |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 months<br>9 weeks                 |                                  |  |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |              |   |   |  |   |  |  |                            |   |                                  |  |  |                                  |  |
| 19a. DATE OF OPERATION   |  |              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |  |                                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |              |   | 21b. TIME OF INJURY<br>HOUR AM. MONTH DAY YEAR<br>8 P.M. 10-26 1979   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Pedestrian struck by Auto   |                            |   |                                  |  |  |                                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Street   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Colesville Rd. Forten Silver Spring Montgomery Md.  |                            |   |                                  |  |  |                                  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |   |   |  |   |  |  |                            |   |                                  |  |  |                                  |  |
| ACTUAL SIGNATURE<br>John S. Bell   |  |              |   | TITLE (SPECIFY)<br>Deputy   |  |   |  | MEDICAL EXAMINER   |                            |   |                                  | DATE SIGNED<br>Jan 3 1980                              |  |                                  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |              |   | ADDRESS   |  |   |  |  |                            |   |                                  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |              |   | 23b. DATE<br>1/7/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Brooks Methodist Church                         |  |  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Calvert County Maryland               |                                  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>Dudley S. Fun Home Inc.  |  |              |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                            |   |                                  |  |  |                                  |  |



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LIBRARY



1944  
1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

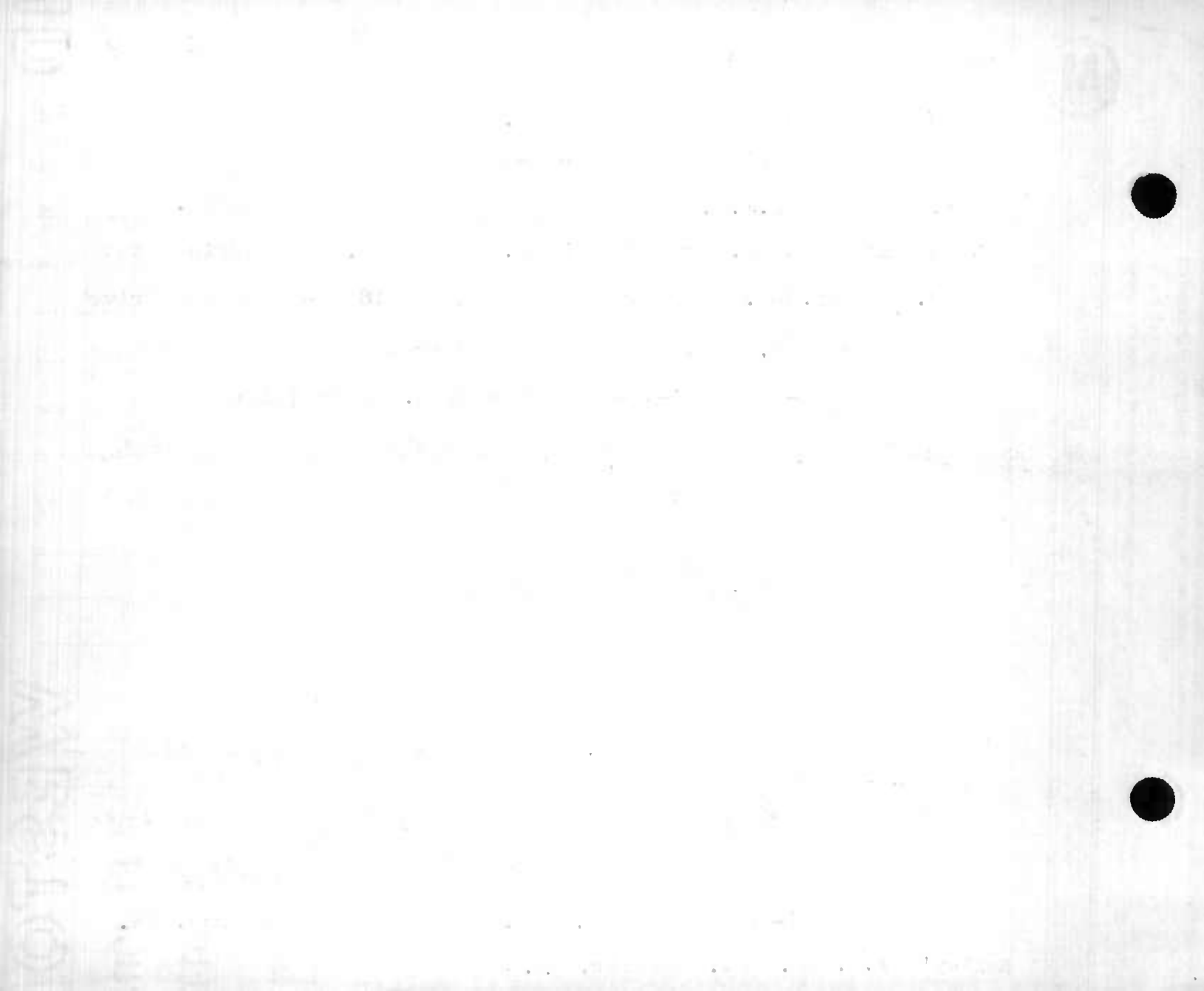
8 0 0 2 2 0 6

REG. NO.

|  |   |  |   |                                      |  |
|--|---|--|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH  |   | 2b. HOUR                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | MONTH DAY YEAR   |   | MONTH DAY YEAR                       |  |
| ARTHUR F. WOODS  |   | JAN. 2 1980  |   | 11:47 AM                             |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR                   |  |
| MALE   | White   | MONTH DAY YEAR   | 71 YRS.   | MONTHS DAYS HOURS MIN.               |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| Takoma Park  | Wash. Adventist Hosp.                                   | Ret. Gulf Service Station  |   | Owner                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| Va.  | U.S.A.  |  |   | Mont. MD.                            |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |  |
| Md.  | Pr. Geo.  | Chillum  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1816 - Longford Drive                |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                        |                                      |  |
| Charles A. Woods   | Margaret Loveless                                       |  | 16b. SOCIAL SECURITY NO.  |                                      |  |
|  |   |  | 577-09-6815   |                                      |  |
| 17. INFORMANT  |   |  | 17. ADDRESS   |                                      |  |
| Dorothy S. Woods (Wife)  |   |  | Same as Above   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |   |                                      |  |
| PART I. DEATH WAS CAUSED BY  |   |  |   |                                      |  |
| IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>  |   |  |   |                                      |  |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>   |   |  |   |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u>  |   |  |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |  |   |                                      |  |
| <u>Pneumonia - pleuritis</u>   |   |  |   |                                      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |  |
|  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                                      |  |
|  | HOUR A.M. MONTH DAY YEAR                                |  |   |                                      |  |
|  | P.M. 19   |  |   |                                      |  |
| 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY                                    | 21f. LOCATION  |   |                                      |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          | STREET CITY OR TOWN COUNTY STATE   |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1980</u> to <u>January 2, 1980</u> , that (I) <del>last</del> saw the deceased alive on <u>January 1, 1980</u> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death. |   |  |   |                                      |  |
| 22b. SIGNATURE   |   | DEGREE   |   | 22c. DATE SIGNED                     |  |
| <u>Joseph T. Hurd</u> M.D.   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 1-2-80                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS   |   |                                      |  |
|  |   | 9801 Denigra Ave, Silver Spring, Md.   |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |                                      |  |
| Burial   | 1-5-1980  | Natl. Mem. Park  | Falls Church, Va.   |                                      |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE RECEIVED BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE           |  |
| NAME ADDRESS   |   | JAN 7 1980   |   | <u>James M. Cuddy</u>                |  |
| Nalley's F.H. Inc. Mt. Rainier, Md.  |   |  |   |                                      |  |

5000

BP

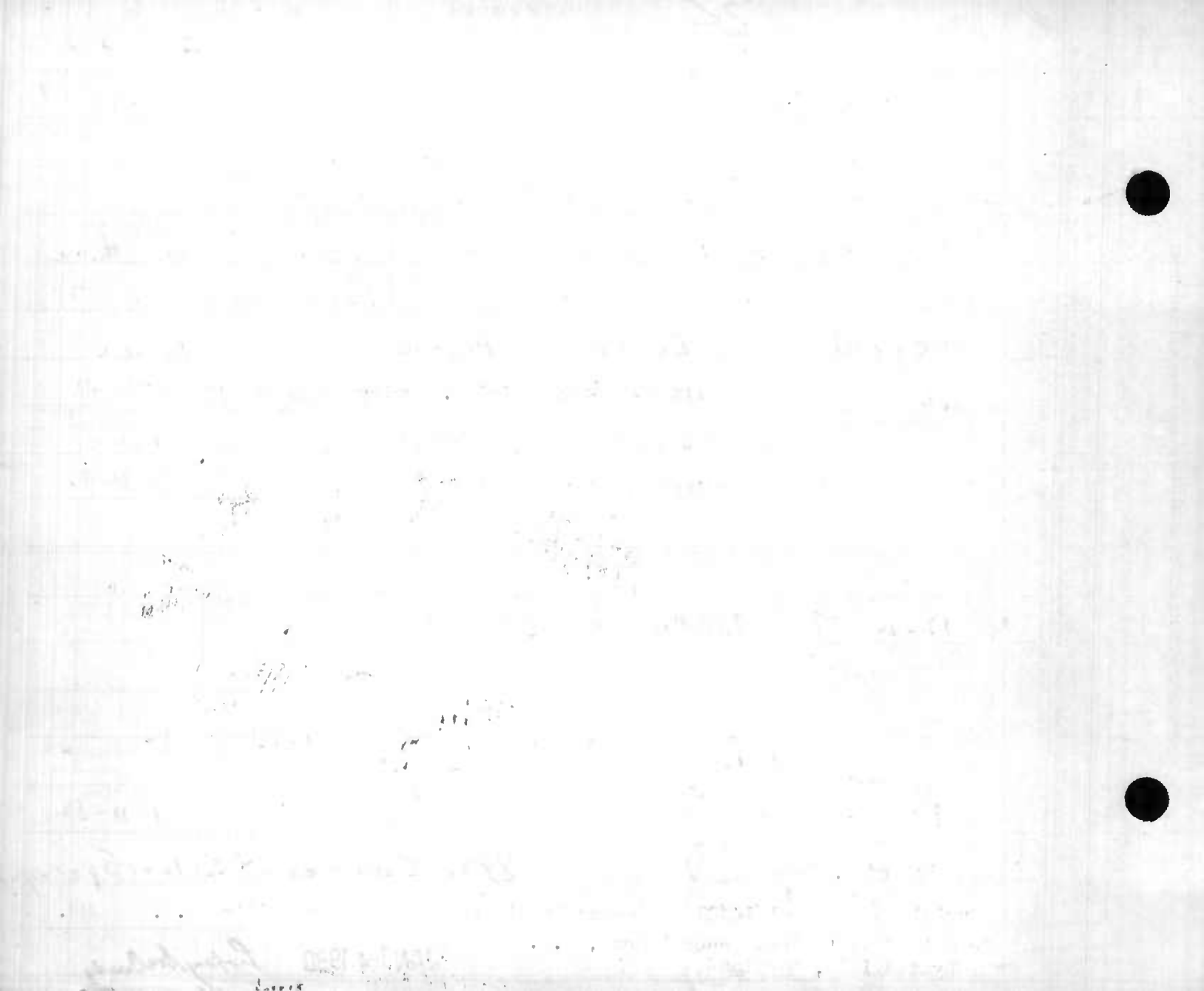


TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial transit permit. These pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                  |  |  |  |
|--|--|--|--|---|--|---|--|----------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO. 8002207   |  |   |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR P M                                 |  |
| ERIKA  |  | WORLEY   |  |   |  |   |  | 1/10/1980                        |  | 3 P  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS      |  | IF UNDER 24 HRS HOURS MIN.                   |  |
| FEMALE   |  | WHITE  |  | 3 18 1923   |  | 56 YRS  |  |                                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                  |  | MD.  |  |
| AUSTRIA  |  | USA  |  |   |  | MONTGOMERY  |  |                                  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                  |  |  |  |
| SILVER SPRING  |  | HOLY CROSS HOSPITAL  |  | HOUSE WIFE  |  | Civil Home  |  |                                  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13d. STREET ADDRESS              |  |  |  |
| MARYLAND   |  | PRINCE GEORGE  |  | COLLEGE PARK  |  |   |  | 9214 DAVIDSON ST.                |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |                                  |  |  |  |
| Leopold  |  | ECKER  |  | Maria   |  | Bohac   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT  |  | ADDRESS   |  |                                  |  |  |  |
| NO   |  | 218-32-2878  |  | Daniel T. Worley  |  | Same as 13 (Husband)  |  |                                  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL METASTASES</u>   |  |  |  |   |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1519 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA - STOMACH</u>   |  |  |  |   |  |   |  |                                  |  | 1 mo.  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |                                  |  | 6 mo.  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |  |
| 12-10-79   |  | CARCINOMA - STOMACH  |  |   |  |   |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                  |  |  |  |
|  |  | P.M. 19  |  |   |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY                           |  | STATE  |  |
|  |  |  |  |   |  |   |  |                                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9 19 79 to 1-10 19 80, that (I) (we) last saw the deceased alive on 1-10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |   |  |                                  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED  |  |                                  |  |  |  |
| Richard L. Cohen   |  | MD   |  |   |  | 1-11-80   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |                                  |  |  |  |
| Richard L. Cohen   |  | 8830 Cameron St. Silver Spring Md.   |  |   |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY                           |  | STATE  |  |
| Burial   |  | 1/14/80  |  | George Washington Cem   |  | Hyattsville   |  | P.G.                             |  | Md.  |  |
| 24 FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                  |  |  |  |
| Francis Gasch's Sons Funeral Home, P.A.<br>Hyattsville, Maryland   |  | JAN 14 1980  |  | L. H. H. H.   |  |   |  |                                  |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 0 0 2 2 0 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Andrew Clifford Wilkins</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 19 80</b>             |   |  | 2b. HOUR<br><b>6:30p</b>   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 29 1883</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebr.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                              |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Examiner at Law</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>                                   |   | 13c. CITY OR TOWN<br><b>Brookmont</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4007--61 St.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew John Wilkins</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vesta Todd</b> |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-36-3316</b>                     |   | 17. INFORMANT<br><b>Daughter</b> ADDRESS<br><b>Raleigh, N.C.</b><br><b>Marjorie W Lindsey. 3213 Birnamwood Rd.</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage -</b><br><b>5326</b> DUE TO, OR AS A CONSEQUENCE OF <b>Source unknown</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <b>Perforated duodenal ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 days</b> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-6 hrs.</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/14/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Perforated duodenal ulcer</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Jan. 14</b> 19 <b>80</b> to <b>Jan. 19</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Jan. 19</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Arthur F. Woodward</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>1/19/80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur F. Woodward</b>   |  |   |  | 22e. ADDRESS<br><b>115 N. Van Buren St.<br/>Rockville, Md. 20850</b>  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland.</b>                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons Inc.</b><br><b>5130 Wisc. Ave., N.W. Wash., D. C.</b>  |  |   |  | 25. DATE REC'D BY REGISTRAR<br><b>JAN 24 1980</b>   |  |  |  |  |  |  |

MEDICAL CERTIFICATION

2  
9

1

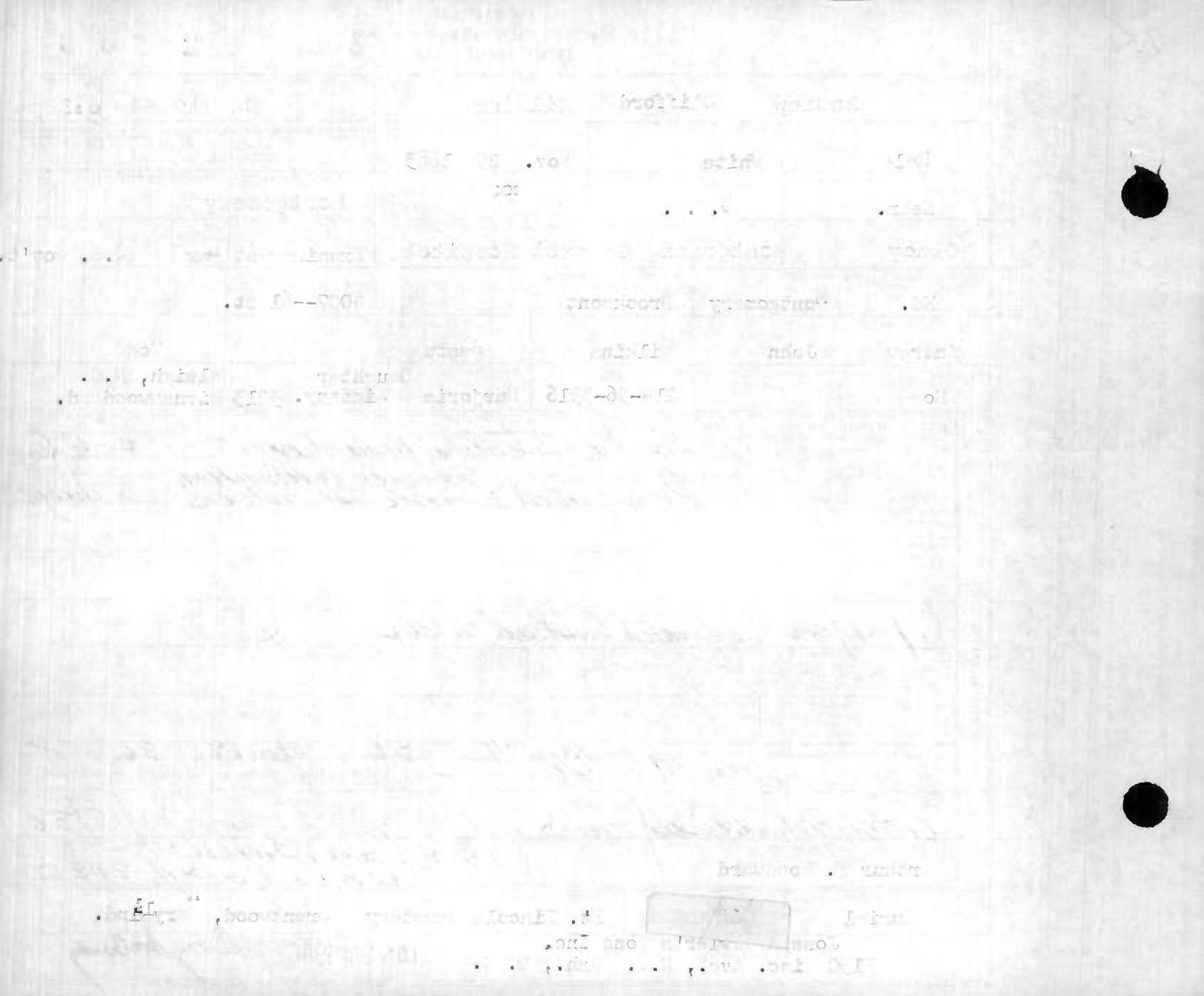
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5800



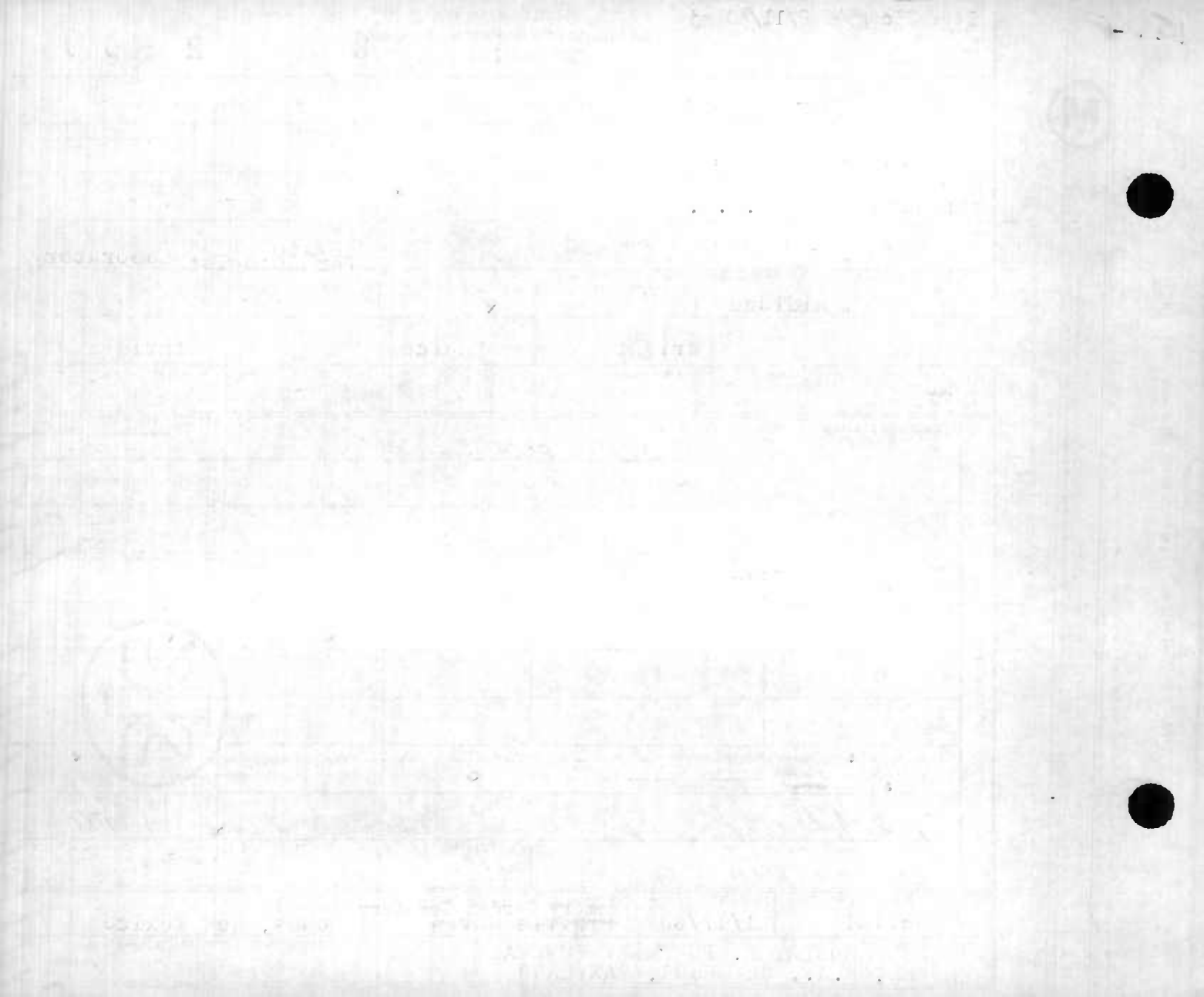


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|   |  |  |  |
|---|--|--|--|
| Item 23c g540 2/11/80 gj  |  | STATE OF MARYLAND  |  |
| 1- FOR STATE REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | 2a DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Mary Anita Wright  |  | MONTH DAY YEAR<br>January 13, 1980   |  |
| 3 SEX   |  | 2b HOUR P M<br>3:40 P M  |  |
| 4 RACE  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
| Female  |  | 39 YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8 AGE (IN YEARS LAST BIRTHDAY)   |  |
| Oklahoma  |  | 39 YRS   |  |
| 7b CITIZEN OF WHAT COUNTRY?   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| U.S.A.  |  | Montgomery County MD   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Bethesda  |  | Clinical Center, Bethesda, Md  |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| Technologist  |  | Laboratory   |  |
| 13a STATE   |  | 13b INSIDE CITY LIMITS?  |  |
| Texas   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 13c CITY OR TOWN  |  | 13d STREET ADDRESS   |  |
| Midland   |  | 4628 Erie St., 79703   |  |
| 14 FATHER'S NAME (FIRST MIDDLE LAST)  |  | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |  |
| Ted Wright  |  | Eunice Ethridge  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.  |  |
| NO  |  | 525-84-8587  |  |
| 17 INFORMANT  |  | ADDRESS  |  |
| Mr. Ted Wright, father  |  | 1200 Lincoln Rd Hobbs, NM 79703  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse histiocytic lymphoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>1 year</u> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Thrombocytopenia</u>   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
|   |  |  |  |
| 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |
|   |  | 21e LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (X) this hospital attended the deceased from <u>January 3, 1980</u> to <u>January 13, 1980</u> that (we) lost above (we) did <u>not</u> view the body after death.   |  |  |  |
| 22b SIGNATURE   |  | 22c DATE SIGNED  |  |
| <u>J. K. Tobacman MD</u>  |  | 1/14/80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS  |  |
| J. K. Tobacman M.D.   |  | National Institutes of Health Clinical Center, Bethesda, Md. 20205                                     |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE   |  |
| Burial  |  | 1/17/80  |  |
| 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE   |  |
| Memory Garden Cemetery  |  | Hobbs, New Mexico  |  |
| 24 FUNERAL DIRECTOR NAME  |  | 25a DATE REC'D. BY REGISTRAR   |  |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND  |  | JAN 22 1980  |  |
|   |  | 25b REGISTRAR'S SIGNATURE  |  |
|   |  | <u>Patricia McCready</u>   |  |



Items #10a-22a Film G540 2/13/80 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02210

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Felicia Gay Yeardeley

2a. DATE KNOWN OF DEATH ESTI- MATED ☒ MONTH DAY YEAR 1 26 19 80

2b. HOUR M 4:56

3. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1968

6. AGE (IN YEARS LAST BIRTHDAY) YRS. 11

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD

10. CITY OR TOWN OF DEATH Olney

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student

12b. KIND OF BUSINESS OR INDUSTRY School

13a. STATE Maryland

13b. COUNTY Mont.

13c. CITY OR TOWN Olney

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 17220 Georgia Avenue

14. FATHER'S NAME FIRST MIDDLE LAST John W. Yeardeley

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Arlene Humphries

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no

16b. SOCIAL SECURITY NO. -

17. INFORMANT ADDRESS John W. Yeardeley Same as # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1/26/ 19 80

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) inhaled exhaust fumes from idling auto

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home

21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17220 Georgia Ave. Olney, Montg. Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE *Thomas D. Smith* TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER DATE SIGNED 1/27/80

EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL Entombment

23b. DATE 1-29-80

23c. NAME OF CEMETERY OR CREMATORY National Memorial Park

23d. LOCATION FAIR'S Church Fairfax Va.

24. FUNERAL DIRECTOR NAME ADDRESS Francis H. Barber Laytonsville, Md. 20760

25a. DATE REC'D. BY REGISTRAR JAN 30 1980

25b. REGISTRAR'S SIGNATURE *Anthony McCready*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

January

1914

January 1, 1914

January 1, 1914

January 1, 1914

January 1, 1914

January 1, 1914

January 1, 1914

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January 1, 1914

January 1, 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 8002211                             |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1a DECEASED NAME (TYPE OR PRINT) <b>FIRST REGINALD MIDDLE H. LAST ZALLES</b><br><i>Reginald H. Zalles</i>                       |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR <b>1 11 1980</b>  |  |   |  | 2b HOUR <b>105 A.M.</b>                      |  |  |  |
| 3 SEX <b>male</b>  |  | 4 RACE <b>white</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>Dec 20 1910</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>    |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Writer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b> |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b> 13b COUNTY <b>Montgomery</b> 13c CITY OR TOWN <b>Bethesda</b>  |  |   |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS <b>6915 Blairdel Road</b>  |  |   |  |  |  |  |  |
| 14 FATHER'S NAME FIRST <b>Jorge</b> MIDDLE <b>Zalles</b> LAST <b>Zalles</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Arcatia</b> MIDDLE <b>Calderon</b> LAST <b>Calderon</b>   |  |   |  |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WWII</b>  |  | 17 INFORMANT <b>Emile C Freeland, Sister.</b>   |  | ADDRESS <b>Chevy Chase, Md. 4803 Grantham Ave</b>   |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>about 2 months</b>   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Peritonitis + pelvic abscess</b>   |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION <b>Jan 2, 1980</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of esophagus</b>   |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |  |  |
| 22a I certify that (i) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>79</b> , to <b>11/10</b> , 19 <b>79</b> , that (i) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 22b SIGNATURE <b>Allen J. O'Neill MD</b>   |  |   |  | DEGREE <b>MD</b>  |  |   |  | 22c DATE SIGNED <b>Jan 11, 1980</b>                   |  |  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen J O'Neill MD</b>   |  |   |  | 22e ADDRESS <b>8601 Old Georgetown Rd Bethesda Md</b>   |  |   |  |   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b DATE <b>1/16/1980</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Bronx, New York</b>   |  |   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR <b>Joseph Lawler's Sons Inc.</b>   |  |   |  |   |  | 25a DATE REC'D. BY REGISTRAR <b>JAN 16 1980</b>   |  | 25b REGISTRAR'S SIGNATURE <b>Harry K. H. H.</b>       |  |  |  |  |  |
| NAME ADDRESS <b>3130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |   |  |   |  |   |  |   |  |  |  |  |  |

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1892



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 02212  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Lilla Virginia Zembower</i>   |  |   |  | 2b. HOUR 8:55 M  |  |  |   |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 30 1898</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i> MD.  |   |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Practical Nurse</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Prince Geo's</i>   |  | 13c. CITY OR TOWN <i>Adelphi</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <i>10512 Truxton Road</i>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Conrad Shatzer</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Sidney Daniels</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  |  |   |
| 16b. SOCIAL SECURITY NO. <i>220-10-4387</i>   |  | 17. INFORMANT <i>Mrs. Lois McMahon</i>  |  | ADDRESS <i>10512 Truxton Rd Adelphi, Md</i>  |  |  |   |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>3489<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <i>Organic brain syndrome.</i><br>(c) <i>Cerebrovascular accident +/or encephalitis.</i> |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immed.</i><br><i>10 days.</i><br><i>10 days.</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Cardiovascular disease</i>   |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>1/20</i> , 19 <i>80</i> , to <i>1/30</i> , 19 <i>80</i> , that (1) (we) lost saw the deceased alive on <i>1/29</i> , 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did/did not) view the body after death.           |  |   |  |  |  |  |   |
| 22b. SIGNATURE <i>James R. Coleman</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <i>1/30/80</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES R. COLEMAN</i>   |  | 22e. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING, MD. 20910</i>   |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>Feb 1/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cumberland Allegany Maryland</i>  |   |
| 24. FUNERAL DIRECTOR NAME <i>Silcox-Merritt Funeral Service</i>   |  | ADDRESS <i>404 Decatur St</i>   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <i>Shirley</i>  |   |





TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 2 2 1 3

REG. NO.

|   |  |  |  |  |                            |  |
|---|--|--|--|--|----------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Rebecca Irene Zembower</u>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><u>1-28-80</u>   |  | 2b HOUR<br><u>10:10 PM</u> |  |
| 3 SEX<br><u>Female</u>  |  | 4 RACE<br><u>White</u>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><u>March 7 1892</u>   |                            |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>87</u> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS<br>HOURS MIN.  |                            |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Pennsylvania</u>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.  |  |  |  |  |                            |  |
| 10 CITY OR TOWN OF DEATH<br><u>Takoma Park</u>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Washington Adventist Hospital</u> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Housekeeper</u>  |                            |  |
| 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |
| 13a STATE<br><u>Maryland</u>  |  |  | 13b COUNTY<br><u>Prince Georges</u>  |  |                            |  |
| 13c CITY OR TOWN<br><u>Beltsville</u>   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William Elliott</u>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Maude Boor</u>                              |  |                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><u>217-10-6745D</u>   |  | 17 INFORMANT<br>ADDRESS<br><u>5005 Lincoln Avenue<br/>Beltsville, Md</u>   |                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Yeast Infection</u><br>1129<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Gangrene left foot with Amputation</u> 32 days<br>(c) <u>Arteriosclerosis obliterans</u> 32 days<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u> |  |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Diabetes Mellitus, Parkinson's Disease, Polyphten, Cystoma, Hypernatremia</u>  |  |  |  |  |                            |  |
| 19a DATE OF OPERATION<br><u>1/17/80</u>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Gangrene left foot</u>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>19</u>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1/28</u> 19 <u>80</u> , to <u>Jan 28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |                            |  |
| 22b SIGNATURE<br><u>Alan R. Gayer MD</u>  |  | DEGREE<br><u>MD</u>  |  | 22c DATE SIGNED<br><u>1/29/80</u>  |                            |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ALAN R. GAYER MD</u>   |  | 22e ADDRESS<br><u>11200 Old Columbia Pike<br/>Silver Spring, Md</u>  |  |  |                            |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b DATE<br><u>Feb 2/80</u>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest Burial Park</u>  |                            |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Cumberland Allegany Maryland</u>  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Silcox-Merritt Funeral Service, Cumberland, Md</u>   |  |  |                            |  |
| 25a DATE REC'D. BY REGISTRAR<br><u>FEB 0 6 1980</u>   |  | 25b REGISTRAR'S SIGNATURE<br><u>Timothy McCready</u>   |  |  |                            |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                              |  |   |  |  |  |   |  | REG. NO. 02214  |  |                              |  |
|--|--|------------------------------|--|---|--|--|--|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>AMELIA ZIEGLER</b>   |  |                              |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-27 80</b> |  | 2b. HOUR<br>M<br><b>1250</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b>      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 1, 1901</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>78 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>78</b>  |  | IF UNDER 24 HRS.<br>HOURS MIN<br><b>78</b>  |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NAMED, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |   |  |  |  |   |  |   |  |                              |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Montg.</b> |  | 13c. CITY OR TOWN<br><b>Potomac</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET ADDRESS<br><b>10809 Rock Run Drive</b>  |  |   |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(Unknown) Rosenham</b>  |  |                              |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(UNKNOWN)</b>  |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |                              |  | 16b. SOCIAL SECURITY NO.<br><b>070-05-0225A</b>   |  | 17. INFORMANT ADDRESS<br><b>Walter C. Ziegler Same as 13</b>   |  |   |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Cardio-Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Fracture of Left Hip</b>  |  |                              |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Diabetes Mellitus - Rheumatoid Arthritis</b>   |  |                              |  |   |  |  |  |   |  |   |  |                              |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                              |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>7:00 P.M. 3/17 85 1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fell down stairs at home</b> |  |   |  |   |  |                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>10809 Rock Run Dr Potomac Montgomery Md.</b>             |  |   |  |   |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                              |  |   |  |  |  |   |  |   |  |                              |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>  |  |                              |  | TITLE (SPECIFY)<br>M.D. <b>Deputy</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>Jan 28, 1980</b>   |  |   |  |                              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball</b>  |  |                              |  | ADDRESS<br><b>7936 Old Georgetown Rd. Bethesda, Maryland</b>  |  |  |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                              |  | 23b. DATE<br><b>Jan. 31, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Orchard Park N.Y.</b>  |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>  |  |                              |  | ADDRESS<br><b>Homes, P.A. Bethesda, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1980</b>   |  |   |  |                              |  |
|  |  |                              |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |                              |  |

